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Attorneys for Respondent
Medical Board of California

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO

BORINA DRAMOV, M.D., Petitioner, v. MEDICAL BOARD OF CALIFORNIA, Respondent.	Case No. 500837 [~~PROPOSED~~] JUDGMENT DENYING PETITION FOR WRIT OF MANDATE Date: December 4, 2002 Time: 9:30 A.M. Dept.: 301 Judge: Hon. James J. McBride

This matter came on regularly for hearing before this Court on December 4, 2002, the Honorable James J. McBride, presiding. Alexander Anolik, Esq., and Jordan A. Lavinsky, Esq., appeared as attorneys for petitioner Borina Dramov, M.D. Lawrence A. Mercer, Deputy Attorney General, appeared as attorney for respondent Medical Board of California.

The record of the administrative proceedings was lodged with the Court, received into evidence and reviewed by the Court. Written and oral arguments having been presented, the matter having been submitted for decision, and based solely on admissible evidence, the Court finds and orders as follows:

IT IS HEREBY ORDERED THAT:

1. The stay heretofore granted in this matter is dissolved;
2. The Petition for Writ of Mandate is DENIED;
3. Petitioner takes nothing by this action; and
4. Respondent is to recover statutory costs in this proceeding.

DATED: MAR 19 2003 ,2003

JAMES J. McBRIDE

THE HONORABLE JAMES J. MCBRIDE
Judge of the Superior Court

ENDORSED
FILED
San Francisco County Superior Court

MAR 1 1 2003

GORDON PARK-LI, Clerk
BY: AUDREY HUIE
Deputy Clerk

CALIFORNIA SUPERIOR COURT, UNLIMITED JURISDICTION

CITY AND COUNTY OF SAN FRANCISCO

DEPARTMENT 301

BORINA DRAMOV, M.D.,
Petitioner,

vs.

MEDICAL BOARD OF CALIFORNIA,
Respondent.

500837

MINUTE ORDER DENYING PETITION FOR WRIT OF MANDATE Re: AWARD OF COSTS

On December 4, 2002, Petitioner Borina Dramov M.D.'s Petition for Writ of Mandate came on regularly for hearing in Department 301 of the above captioned court, the Honorable James J. McBride presiding. Jordan Lavinasky appeared on behalf of Petitioner; Deputy Attorney General Lawrence Mercer appeared on behalf of Respondent Medical Board of California.

The record of the administrative proceedings was lodged, received into evidence, and reviewed by the Court, and the matter was taken under submission for further review. The Court denied Petitioner's Writ, on December 11, 2002, but stayed Respondent's award of costs pending further proof regarding Petitioner's ability to pay. Having considered all further briefings submitted in connection to the award of costs, this court finds as follows:

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IT IS HEREBY ORDERED THAT:

1. The stay placed on Respondent Medical Board of California's award of costs on December 11, 2002, is hereby lifted, and the award shall be in effect as of the date of this order.

2. The Petition for Writ of Mandate is DENIED in its entirety.

Dated: 3/7/03

By: _____
The Honorable James J. McBride
Judge of the Superior Court

#500837
DRAMOV v. MEDICAL BOARD OF CA.

COPY

COURT OF APPEAL, FIRST APPELLATE DISTRICT
350 MCALLISTER STREET
SAN FRANCISCO, CA 94102
DIVISION 1

BORINA DRAMOV, M.D.,
Petitioner,
v.
SAN FRANCISCO COUNTY SUPERIOR COURT,
Respondent;
CALIFORNIA MEDICAL BOARD,
Real Party in Interest.

A101508
San Francisco County No. 500837

BY THE COURT:

The petition for writ of mandate is denied. The stay previously imposed is dissolved.

The justices participating in this matter were:

✓Marchiano, P.J. ✓Stein, J. __Swager, J. ✓Margulies, J.

Date: MAR 05 2003

MARCHIANO, P.J.
P.J.

ordw1

COPY

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION ONE

BORINA DRAMOV, M.D.,

Plaintiff and Appellant,

v.

CALIFORNIA MEDICAL BOARD,

Defendant and Respondent.

A101475

(San Francisco County
Super. Ct. No. 500837)

By the Court:[1]

Review of the superior court's decision concerning revoking, suspending or restricting a medical license may be sought solely by a petition for extraordinary writ. (Bus. & Prof. Code § 2337; *Leone v. Medical Board of California* (2000) 22 Cal.4th 660.)

Therefore, the appeal on file herein is dismissed, and this court's January 29, 2003 notice is vacated.

The Clerk of this Court shall refile the petition for writ of supersedeas and request for temporary stay (filed January 30, 2003) as a petition for writ of mandate or other extraordinary relief under **new case number A101508**.

On or before **4:00 p.m., Monday, February 10, 2003**, petitioner shall serve and file a verified petition, all exhibits, and a memorandum of points and authorities addressed to the merits of her claims, in compliance with California Rule of Court, rule 56.

Pending consideration of the petition, and subject to further order of this Court, the Decision of the Medical Board of California in The Matter of the Accusation Against Borina Dramov, M.D., file number 03-1998-88144 is temporarily stayed.

Date: JAN 31 2003 MARCHIANO, P.J. P.J.

[1] Before Marchiano, P.J., Stein, J., and Margulies, J.

CALIFORNIA SUPERIOR COURT, UNLIMITED JURISDICTION

CITY AND COUNTY OF SAN FRANCISCO

DEPARTMENT 301

BORINA DRAMOV, M.D.,

Petitioner,

vs.

MEDICAL BOARD OF CALIFORNIA,

Respondent.

500837

MINUTE ORDER ON PETITION FOR WRIT OF MANDATE

On December 4, 2002, Petitioner Borina Dramov M.D.'s Petition for Writ of Mandate came on regularly for hearing in Department 301 of the above captioned court, the Honorable James J. McBride presiding. Jordan Lavinasky appeared on behalf of Petitioner; Deputy Attorney General Lawrence Mercer appeared on behalf of Respondent Medical Board of California.

The record of the administrative proceedings was lodged, received into evidence, and reviewed by the Court. Upon consideration of all the papers submitted and oral arguments presented at the hearing in connection with this matter, and the matter having been submitted for decision, the Court finds as follows:

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IT IS HEREBY ORDERED THAT:

1. The Petition for Writ of Mandate is DENIED.
2. The award of costs to Respondent Medical Board of California is STAYED.
3. The parties are directed to submit within five (5) days of service of this order, memoranda not to exceed five (5) pages, including points and authorities, on the issue of the costs awarded to Respondent Medical Board of California. Petitioner is to submit evidence of her ability to pay those costs in the form of an income & expense declaration, and both parties may cite any relevant legal authorities supporting or challenging the costs awarded.

SO ORDERED:

Dated: 12/10/02

By: _____
The Honorable James J. McBride
Judge of the Superior Court

ALEXANDER ANOLIK, ESQ., STATE BAR NO. 042685
JORDAN A. LAVINSKY, ESQ., STATE BAR NO. 192215
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ATTORNEYS FOR: RESPONDENT BORINA DRAMOV, M.D.

IN THE CALIFORNIA SUPERIOR COURT

IN AND FOR THE COUNTY OF SAN FRANCISCO

BORINA DRAMOV,

Petitioner/appellant,

v.

MEDICAL BOARD OF CALIFORNIA,

Respondent.

Case No. 500 837

ORDER GRANTING STAY PENDING APPEAL

Petitioner's Petition for a Stay Pending Appeal in the above captioned action came on for hearing April 23, in Room 301. Jordan Lavinsky of Alexander Anolik, A Professional Law Corporation, appeared for Petitioner, Lawrence Mercer, appeared on behalf of Respondent Medical Board of California.

After full consideration of the moving papers, and argument of counsel, and good cause appearing:

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IT IS HEREBY ORDERED that the Decision of the Medical Board of California in The Matter of the Accusation Against Borina Dramov, M.D., file number 03 1998 88144 be stayed pending appeal. Such stay of enforcement shall remain in effect until the remittitur is issued in the instant appeal.

Dated: April ____, 2002.

APR 2 3 2002

JAMES J. McBRIDE

JUDGE OF THE SUPERIOR COURT

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	No. **03-1998-88144**
BORINA DRAMOV, M.D.	)	
Physician and Surgeon's Certificate No. G 11513	)	
Petitioner	)	

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Jordan A. Lavinsky, Esq., attorney for Borina Dramov, M.D., for reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on April 22, 2002.

IT IS SO ORDERED: April 22, 2002

David T. Thornton
Chief of Enforcement
Medical Board of California

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **BORINA DRAMOV, M.D.** Certificate No. G 11513 Respondent	)	No. 03-1998-88144 **ORDER GRANTING STAY**

Borina Dramov, M.D. has filed a request for a stay of execution of the Decision in this matter with an effective date of April 12, 2002.

Execution is stayed until 5:00 p.m. on April 22, 2002.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: April 12, 2002

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

By: _____
DAVID T. THORNTON
Chief of Enforcement

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
	)	
BORINA DRAMOV, M.D.	)	**File No. 03 1998 88144**
	)	
Physician's and Surgeon's Certificate No. G 11513	)	
	)	
	)	
Respondent.	)	
	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on April 12, 2002 **.**

IT IS SO ORDERED March 13, 2002 **.**

MEDICAL BOARD OF CALIFORNIA

By: 

Hazem H. Chehabi, M.D., Chair
Panel A
Division of Medical Quality

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: BORINA DRAMOV, M. D. 2107 Van Ness Avenue, Suite 100 San Francisco, CA 94109 Physician's and Surgeon's Certificate No. G 11513 Respondent.	Case No. 03 1998 88144 OAH No. N2001080489

PROPOSED DECISION

This matter was heard before Administrative Law Judge Jonathan Lew, State of California, Office of Administrative Hearings on December 10 and 11, 2001, in San Francisco, California.

Complainant was represented by Lawrence A. Mercer, Deputy Attorney General.

Respondent Borina Dramov, M.D., was present and represented by Nathan Cohn, Esq. and Jordan A. Lavinsky, Esq., Alexander Anolik, A Professional Law Corporation, 2107 Van Ness Avenue, Suite 200, San Francisco, CA 94109.

Submission of the case was deferred pending receipt of complainant's Opposition to Respondent's Motion to Dismiss Accusation, and of respondent's reply to same. They were received on December 21, 2001 and January 7, 2002, respectively. Respondent's Motion to Dismiss Accusation and Reply were marked as Exhibits D-1 and D-2 for identification. Complainant's Opposition was marked as Exhibit 19 for identification.

The case was submitted for decision on January 7, 2002.

FACTUAL FINDINGS

1. Complainant Ron Joseph brought the Accusation and First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On December 20, 1965, the Board issued Physician's and Surgeon's Certificate Number G 11513 to Borina Dramov, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to this matter and will expire on May 31, 2002, unless renewed.

3. On October 26, 2000, the Board filed an Accusation against respondent, and on November 15, 2001, a First Amended Accusation was served on her. The charges relate to her care and repeat hospitalization of seven patients. Complainant contends that respondent prescribed bed rest, traction and in-patient medication to these patients and that this treatment was outmoded, ineffective and, in at least one case, contraindicated. Complainant alleges that respondent engaged in repeated negligent acts and/or incompetence with regard to these patients. Complainant also alleges that her actions constituted gross negligence with regard to one patient who was prescribed traction despite a diagnosis of cervical myelopathy.

Complainant believes that respondent has committed numerous departures from the standard of care by admitting and readmitting patients to the hospital for bed rest and traction, and doing so with such frequency that respondent should have recognized that such treatment was ineffective, and that she should have pursued more effective treatment alternatives.

4. Background. Respondent did her undergraduate work at the University of California Los Angeles before attending the University of Southern California School of Medicine. She completed a rotating internship at Cedars/Sinai Medical Center, Los Angeles. She then completed a neurology residency at the California Pacific Medical Center in San Francisco. This included two separate three-month fellowships at the University of California San Francisco School of Medicine. She remains board eligible in neurology. She cites family issues as factors in her not becoming board certified. She was a clinical instructor in neurology to interns and residents at Children's Hospital until 1985. She had staff privileges at St. Mary's Hospital, Ralph K. Davies Medical Center/Pacific Presbyterian. Except for St. Mary's she had not worked with any hospitals over the last three years. Since 1998 she has basically limited her practice to workers compensation. She has no hospital privileges at this time.

Respondent holds memberships in the American Academy of Neurology, Western Federation of Neurology, California Neurological Association and the San Francisco Neurological Society. She has presented one paper before the Western Federation of Neurology, and published two articles in the *Transactions of the American Academy of Neurology* and *Archives of Neurology*.

5. Respondent has worked in private practice as a neurologist for over 25 years. She was on staff at St. Mary's Medical Center through April 1999. In March 1999, St. Mary's Medical Center brought an action to terminate her admitting privileges on essentially the same facts presented in this case. The same patients are involved. Her privileges were terminated. After exhausting her administrative remedies she filed a Petition for Writ of

Mandate and on November 3, 2000 it was granted. The Superior Court determined that her conduct did not endanger her patients or cause them injury.

6. Respondent acknowledges that she treated the patients at issue with hospitalization for four to five days of complete bed rest, except for bathroom privileges, continuous traction, muscle relaxants, anti-inflammatory drugs and narcotic medications, controlled, for severe pain. Patient histories, medical profiles/diagnoses, treatment plans and hospitalizations for each of the seven patients at issue are summarized below.

7. Patient A.S. She is a 60-year-old who came under respondent's care with complaints of chronic back and neck pain. A 1984 CT scan had revealed a right L4-5 central and right posterolateral disc protrusion, and a 1988 CT scan revealed moderate, broad-based posterior protrusion of the L5-S1 and the L4-5 discs. Hypertrophic degenerative changes were also noted. A.S. presented with back pain in June 1993 following a fall down a flight of stairs. Magnetic Resonance Imaging (MRI) of the lumbar spine was performed on June 8, 1993. The radiology report described generalized lumbar disc degeneration and facet arthrosis, with the degeneration more marked at L4-5, and left lateral protrusion or herniation at L4-5.

Computerized Tomography (CT) was performed on June 10, 1993. The report noted that the left-sided epidural process seen on previous MRI examination appeared to represent severely advanced left L4-5 facet arthropathy with heavy calcification along spurs at the medial aspect of the facet. Left-sided narrowing of the canal and left L4-5 foramen, along with mild stenosis at L4-5 were also noted.

8. A.S. was hospitalized between June 7 – 16, 1993. She was treated with traction immobilization. Following discharge A.S. was hospitalized on eight more occasions through July 13, 1996. Respondent characterizes subsequent admissions as "acute exacerbations of her chronic neck and back condition" and points to various events and activities including a slip and fall from a two-step ladder, auto accident (braking to avoid hitting a bicyclist), caring for an elderly parent that involved intermittent lifting and pulling a heavy vacuum cleaner. The hospitalizations were as follows:

a. July 14 – 21, 1993. A.S. was hospitalized for increasing left leg pain and weakness and numbness in the right leg, which symptoms were attributed to the May 1993 fall down a flight of stairs. Physical examination found tender lower back with positive bilateral straight leg raising. Left knee and ankle jerks were suppressed. Respondent diagnosed A.S. with acute lumbar radiculopathy secondary to herniated disc. She was treated with continuous traction immobilization, intramuscular medications and muscle relaxants.

b. November 12 – 16, 1993. A.S. was hospitalized by reason of increasing severe back pain radiating into both buttocks, left thigh and calf with associated numbness in the left thigh. She reported falling down a flight of stairs in July 1993. Respondent's impression was "Acute L5-S1 lumbar

radiculopathy secondary to hernia of lumbar L4-L5 disk with pressure direct pressure on the left L5 nerve root." Hospital course was to treat A.S. conservatively with continuous traction, immobilization, intramuscular medications and muscle relaxants.

c. December 9 – 13, 1993. A.S. was hospitalized with acute back pain radiating to both buttocks and into the left thigh and calf. It was precipitated by lifting a grocery bag several weeks previous. Findings included tenderness over the left sciatic notch and positive bilateral straight leg raising. Respondent diagnosed her with acute L5-S1 lumbar radiculopathy. She was treated conservatively with continuous traction, immobilization, medications and muscle relaxants.

d. July 22 – 27, 1994. A.S.'s admission diagnoses included acute cervical radicular pain, acute L5-S1 lumbar radiculopathy and acute cervical and lumbar sprain. She had complaints of acute onset of stiffness and pain in the neck radiating to her shoulder and upper arms, and acute severe lower back pain radiating to the left thigh and calf across the buttocks. She had slammed her brakes during a collision with a bicycle. A.S. was treated with conservative continuous traction, immobilization, intramuscular medications, muscle relaxants and heat.

e. December 8 – 13, 1994. A.S. was hospitalized after slipping and falling hard on a wet kitchen floor. She developed increasing severe back pain and spasm radiating across both buttocks and into her left thigh and calf. Findings included symmetrical upper extremity reflexes, tender low back with spasm and tender sciatic notch, positive straight leg raising left greater than right, depressed left knee and ankle jerks, weak foot extensors, and an L5-S1 sensory loss. Respondent's impression was acute lumbosacral sprain, acute L5-S1 lumbar radiculopathy. A.S. was treated with continuous traction and immobilization and intramuscular medication. She also was given medication for muscle spasms and heat and continuous traction.

f. June 12 – 17, 1995. A.S. was admitted with complaints of acute neck pain, right arm pain and back pain. It was precipitated after pulling a vacuum cleaner. An MRI revealed severe degenerative changes and osteophytes and spurring at C5-6, C6-7, disc bulge at C5-6, osteophytes left paracentral at the C6-7 area with foraminal stenosis bilaterally, left greater than right. A.S. received conservative treatment consisting of continuous traction with immobilization, intramuscular medications and muscle relaxants.

g. May 13 – 18, 1996. A.S. was hospitalized with complaints of severe pain in the back radiating to the right thigh and calf. It was precipitated by a bad fall she suffered while trying to lift up her mother. Examination showed asymmetric upper and lower extremity reflexes, weakness of the right foot

extensor muscles, positive straight leg raising bilaterally, a normal sensory exam and painful gait. Respondent diagnosed her with "Acute L5-S1 lumbar radiculopathy, right more than left, right sided." A.S. was treated with continuous traction, immobilization, intramuscular medications and muscle relaxants.

h. July 8 – 13, 1996. This was the last of the hospitalizations. A.S. was admitted for lower back pain radiating down posteriorly to her left thigh and calf. Respondent related the pain back to the May 1996 fall. Examination showed a tender low back, positive straight leg raising bilaterally, weakness of the left foot extensor muscles and decreased sensation in the L5-S1 distribution. The diagnosis was acute L5-S1 level radiculopathy, left more so than right, and acute lumbar sprain. Treatment was with continuous traction, immobilization and muscle relaxants.

9. Kurt V. Miller, M.D. was qualified as an expert medical witness. He specializes in neurology and chronic pain management and is board certified by the American Board of Psychiatry ad Neurology. He practices with Fresno Neurological Associates and was the past medical director of Hearts Plus. Dr. Miller has reviewed the medical records and treatment history of A.S. and the other patients in this case.

Dr. Miller opines that it is no longer the standard of care to treat neck and back pain with bed rest and traction. It was the standard at one time. However, by the early 1980s it was recognized that shorter rather than longer bed rest had better outcomes, and by the end of the 1980s bed rest and traction were considered outmoded and suboptimal for back pain. He notes that medical authorities dissociated themselves from traction based on 1987 studies, and that medical textbooks incorporated this viewpoint by 1990. Dr. Miller characterizes the standard of care for treating neck and back pain as having evolved to the point that bed rest and traction are now viewed as deleterious because of associated deconditioning effects, muscle loss and cardiovascular decline. It is no longer indicated for the management of back pain. Dr. Miller does not believe hospitals even retain traction equipment any more for inpatient treatment of back/neck injuries.

Dr. Miller suggests that the appropriate treatment for an individual such as A.S. would include physical therapy, the aggressive use of oral analgesics including nonsteroidal anti-inflammatory agents and perhaps narcotics on a long term basis. If such interventions do not provide adequate relief, consideration should be given to analgesic and/or steroid injection of the facet joints. He does not criticize respondent's use of intramuscular Demerol, but he believes there are better alternatives such as morphine that do not pose the central nervous system risks associated with Demerol.

Dr. Miller views the use of traction and bed rest to be a departure from the standard of care, or negligence.

10. Dr. Miller does not find respondent's diagnosis of A.S. to be reasonable. He opines that it is quite rare to have radiculopathy at more than one level. This diagnosis was based on respondent's physical examination findings of multiple levels of reflex, motor and sensory changes. [1] Radiculopathy is injury to a nerve root and Dr. Miller believes that to have radiculopathy at more than one level is so exceptional that the standard of care would require convincing evidence on specific testing before such a diagnosis was pronounced.

Dr. Miller also criticizes respondent's failure to develop a differential diagnosis. He suggests that she became fixed on radiculopathy, except for a single mention of sprain. Because radiculopathy is a rather rare cause, accounting for no more than a small percentage of such complaints, Dr. Miller believes a more likely diagnosis would be cervical and lumbar arthropathy, leading to arthritis type pain. Dr. Miller notes that respondent persisted in ascribing pain to radiculopathy to such degree that she ignored imaging findings in favor of physical findings that were "nonsensical."

11. Dr. Miller raises another point, largely one of semantics. He suggests that respondent has some difficulty with the concept of "acute" illness. The recurrent pain described by A.S. would not be described as an acute process, but rather one that is chronic and recurrent. Respondent does not disagree. However, she chooses to characterize it as an acute episode of a chronic condition. She believes that if one suffers an episode of acute intense pain, not capable of being controlled, with some origin/relationship to a chronic condition – the implication that one is not entitled to receive treatment for "acute" pain is simply incorrect. Dr. Miller and respondent both understand that such occurrences are an exacerbation of an underlying condition.

Dr. Miller is perhaps overly critical on this point, reading too much into respondent's choice of words. She understands the concepts of "acute" and "chronic" illness.

12. Respondent believes the multiple hospital admissions and her treatment of A.S. were appropriate. She cites to medical articles as recent as 2001 in support of traction and bed rest for acute episodes of back pain. Respondent notes that many kinds of treatment are available, and that different patients respond differently to these treatment modalities. She views traction/bed rest as a relatively conservative treatment and she disagrees with the alternatives suggested by Dr. Miller. For example, she believes that treating chronic pain with only narcotics is an easy way for patients to become addicted. She does not believe in putting patients on heavy narcotics, epidural injections, morphine pumps or similar regimens. Respondent believes epidural injections are waning in popularity and that certain studies have shown steroid injections to be no more effective than placebo injections. In general, she believes that the worse thing one can do for patients with chronic diseases is to make them dependent upon drugs.

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[1] Dr. Miller comments: "Particular standouts included her reports of straight leg raising as being positive (for this to be so one must describe radicular findings, not back pain), L5 sensory changes to the thigh (there is no L5 sensory area above the knee), diminished reflexes of an entire extremity (unlikely, in that this involves multiple nerve root levels), and diminished strength in entire extremity (unlikely for the same reason as reflexes)."

She has related concerns with outpatient pain clinics and the practice of providing patients with triplicate prescriptions for use in a home environment. She notes that taking large amounts of anti-inflammatory medications, for example, may result in kidney problems. She would rather supervise the administration of medications, particularly narcotics, in a controlled hospital setting. Respondent has used nonsteroidal anti-inflammatory drugs (NSAID) for her patients, but not on an intensive basis, and she does prefer NSAID over narcotics.

13. Respondent no longer uses traction and has not done so in the last three years. When she did prescribe traction she did so as a form of immobilization to insure complete bed rest. Pelvic traction that she prescribed was at most 20 pounds, and cervical traction was less than 5 pounds. She believes such traction helped ease nerve root irritation and was effective in alleviating acute episodes of back and neck pain. She notes that she received no criticism of this practice until 1998, and that such was really prompted by her frequent hospitalization of low-income patients and consequent loss of hospital revenue. As to the practice being outmoded, she notes that the traction equipment was available at and supplied by St. Mary's Hospital, that it continues to be available as a part of physical therapy and that every hospitalization at issue satisfied Medicare and/or MediCal criteria.

14. Respondent stands by her clinical diagnosis of radiculopathy. She avers that it is simply not true that to have more than one level of nerve root involvement is rare. She explains that pain radiating to the left thigh or calf as in the case of A.S. may be L5 or L5-S1, and that ankle jerk can be due to L5 or S1. Reference to them both is therefore appropriate. When she described nerve root irritation at L4-L5 she was roughly describing the nerve root involvement and she maintains that more than one nerve root can be involved. Importantly, she contends that radiculopathy is a clinical diagnosis, and not one that can be based on MRI findings. The more important factors in making a diagnosis of radiculopathy are the history and distribution of the pain. That is what she relied upon in this case. She believes that all of the neurological findings for A.S. on examination were consistent with radiculopathy, and that her diagnosis was further confirmed by lumbar and cervical MRI findings.

15. Patient D.A. He came under respondent's care and treatment at St. Mary's Hospital and Medical Center in December 1992. At that time he was age 67 and had been involved in a rear end collision on November 21, 1992. His medical history included a 1985 lumbar laminectomy and discectomy L4-5, a 1986 lumbar laminectomy and discectomy L5-S1, a 1988 severe pelvic fracture and right hip replacement, a 1989 fusion L4-S1, and arthroscopic surgery in 1991.

He was admitted on December 2, 1992 with complaints of acute neck and lower back pain, radiating into both buttocks and thighs. Neck pain radiated into both shoulders, right more than left. MRI examination of the neck and back revealed disc bulges at L2-3 and L3-4, degenerative changes at the T2 level and a possible benign compression fracture at that same level. There was no root compression, disc disease or arachnoiditis. Respondent diagnosed him with: 1) acute cervical extensor-flexor injury sprain, acute lumbar sprain; 2)

acute cervical C6-7 greater than C5-6 radiculopathy; and 3) lumbar radiculopathy L5-S1 bilateral.

D.A. was treated conservatively with traction immobilization, intramuscular medications and muscle relaxants. He was discharged on December 10, 1992, to be followed in the office.

16. D.A. was thereafter hospitalized on eleven different occasions through July 22, 1995. Respondent avers that all of D.A.'s hospital admissions were prompted by acute exacerbations of his chronic condition: severe intractable neck pain radiating into his right arm, and unrelenting, intractable back pain radiating into the buttocks and thighs, worse on the left, with foot drop on the left related to the arachnoiditis. She describes him as being inoperable. Hospitalizations were directed at pain control, rest with immobilization (traction) to make his life more bearable. The hospitalizations were as follows:

a. March 15 – 20, 1993. D.A. was admitted with "acute back pain" relating back to the November 21, 1992 rear end collision. The back pain was radiating into the lower back across the back into the left buttock and thigh. A lumbar MRI showed no acute changes, no spinal stenosis, no disc herniation and no nerve root impingement or arachnoiditis. There was diffuse facet arthrosis and lumbar disc degeneration. Respondent's diagnosis was acute lumbar radiculopathy L5-S1 and L4-5, and cervical radidicular pain C6-7. D.A. was treated conservatively with traction, immobilization, medications and muscle relaxants.

b. June 7 – 15, 1993. Respondent admitted D.A. for "acute neck and back pain" attributed to two automobile accidents (11/21/92 and 1/13/93). Neck pain was described as radiating to his right shoulder and back pain was described as stabbing and radiating to the right buttock and into the right thigh. Respondent's impression was: 1) acute L5-S1 lumbar radiculopathy, 2) cervical C6-7 radiculopathy, acute right greater than left, and 3) acute lumbar cervical sprain. While in the hospital he was treated continuously with immobilization, traction as well as muscle relaxants. He was discharged to be followed with outpatient physical therapy.

c. August 23 – 28, 1993. D.A. was admitted for a chief complaint of several weeks increasing low back pain and right leg pain and weakness. Physical examination was said to show asymmetrical reflexes in all extremities, profound extensor hallucis longus (EHL) weakness, left greater than right. Straight leg raising was positive bilaterally. Respondent's impression was acute L5-S1, L4-5 lumbar radiculopathy, right greater than left. D.A. was treated conservatively with traction, immobilization, intramuscular medications, muscle relaxants. He improved to the point where he could walk and could manage at home and was discharged to be followed on an outpatient basis.

d. December 6 – 12, 1993. D.A. was hospitalized for increased neck pain radiating to both shoulders and the right arm, and increasing left foot drop ascribed to the collision on January 13, 1993. Findings showed asymmetry of reflexes, positive straight leg raising and leg weakness. Respondent's diagnoses included acute cervical C6-7, C5-6 radiculopathy on the right, acute L5-S1 lumbar radiculopathy, left greater than right with foot drop increasing and cervical spondylosis. D.A. was treated conservatively with traction, immobilization, intramuscular medications and muscle relaxants.

e. February 23 – 28, 1994. D.A. was admitted with complaints of recent onset of acute severe neck pain radiating to the right shoulder and upper arm, and acute lumbosacral pain radiating to both buttocks and thighs, right greater than left. Examination showed variable reflexes, left leg weakness and sensory loss. Respondent's diagnosis was acute cervical lumbar sprain, acute C5-6 and C6-7 cervical radiculopathy, and acute L4-5 lumbar radiculopathy right greater than left. Treatment was as before with traction, immobilization and intramuscular medications and muscle relaxants.

f. June 8 – 13, 1994. D.A. was admitted with acute back pain and increasing left leg weakness. The pain was of such intensity that he could barely walk and he was unable to manage at home. Examination showed positive straight leg raising, asymmetric reflexes and atrophy of his left leg. Respondent's diagnosis was acute L5-S1 lumbar radiculopathy with progression, and left leg weakness. An MRI of the lumbar spine revealed again foraminal narrowing on the right at L4-5, and bilaterally at L5-S1, and epidural fibrosis of L3-4 and L4-5, right greater than left. D.A. was treated with continuous traction, immobilization, intramuscular medications and muscle relaxants.

g. September 26 – 29, 1994. D.A. was hospitalized for acute, sharp pain across the lower back, radiating down both buttocks and both thighs, especially the left. It was precipitated by his bending over to pick up something. Examination showed positive straight leg raising, tenderness and muscle spasm on the back. D.A. was treated conservatively with continuous traction, immobilization, medications and muscle relaxants. His discharge diagnosis was "Acute lumbar sprain and acute L5-S1 lumbar radiculopathy."

h. December 19 – 22, 1994. D.A. was admitted with acute onset of severe sharp pain in the lower back brought on by sitting. Examination showed asymmetric reflexes, tender low back, positive leg raising, left greater than right and left leg weakness. Respondent diagnosed him with "Acute L5-S1 lumbar radiculopathy." An MRI taken on December 20, 1994 showed moderately advanced osteoarthritis and moderate sized left hip joint effusion. He was treated conservatively as before with traction, immobilization, and intramuscular medications.

i. February 22 – 24, 1995. D.A. was hospitalized with complaints of increasing severe lower back pain radiating to the left thigh and calf and left groin. He could barely walk. Examination showed positive straight leg raising, weakness of left EHL, and slight decreased sensation to pinprick over the left L5-S1 dermatomal distribution. Respondent diagnosed him with acute L5 lumbar radiculopathy. He was treated conservatively with traction, immobilization and intramuscular medications.

j. April 24 – 28, 1995. D.A. was admitted for acute left lower extremity weakness with complaints of sharp low back pain radiating to the left leg. Findings included asymmetric reflexes, positive straight leg raising, weak left EHL and quadriceps and sensory loss in the L5-S1 dermatome. Respondent's diagnosis was acute L5-S1 lumbar radiculopathy. D.A. was treated conservatively with continuous traction, immobilization, intramuscular medications and muscle relaxants.

k. July 17 – 22, 1995. D.A. was admitted to the hospital with acute, severe lower back pain radiating to the right buttock, thigh and calf. He was age 70. Physical examination findings included asymmetric reflexes, tender low back, weak right anterior tibialis, and left EHL. Respondent's diagnosis was acute lumbar radiculopathy, L5-S1, right sided, and cervical disc disease by history. He was treated as before.

17. Dr. Miller finds that the same issues raised in connection with A.S. are present here. He opines that she departed from the standard of care in the following respects:

> Problems include the unsubstantiated diagnosis of radiculopathy and a notion that such might occur at multiple levels, both cervical and lumbar, concurrently. As pointed out above, such occurrence is quite unusual. The diagnosis of multilevel radiculopathy does not explain the patient's presentation of, nor correspond with the MRI findings. It would appear that left hip arthritis (12/20/94) with effusion, found on MRI scanning, was a more likely cause of the patient's complaints. Dr. Dramov failed to demonstrate an adequate understanding of the causes of such complaints, in particular, she failed to recognize that back or neck pain into the extremities can arise from other processes than radiculopathy.
>
> Treatment for back pain with pelvic traction was outmoded at that time.

18. Dr. Miller points to respondent's repeated failure, in this and other cases that he evaluated, to look for other causes of pain apart from radiculopathy. For D.A. he believes hip arthritis should have been included as part of a differential diagnosis given the MRI findings. Even if her diagnosis was correct, he believes the treatment was not appropriate. He views hospitalization, bed rest, traction and muscle relaxants as below the standard of care, even potentially harmful had any atrophy led to the need for hip replacement. Rather, he believes D.A. should have been prescribed narcotic medication on an outpatient basis.

Respondent notes that D.A. did have a right hip replacement in February 1988, and that the hospital admissions were not for his hip. D.A. had been seen by a number of other physicians and respondent believes he went through 42 diagnostic procedures. She avers that surgery was not the answer for him and that no one would touch him. Her goal in each instance was to address acute exacerbation of his painful condition. She would not prescribe narcotics to him on an outpatient basis because she believes many people do not wish to take narcotics and they can be managed without narcotics if treated appropriately as she believes she did.

19. Patient L.W. Respondent saw L.W., a 43-year old merchant marine, in February 1997. He had been struck earlier in October 1993 by a vehicle and he suffered momentary unconsciousness and temporary quadriplegia. He was admitted for two months at a Guam hospital where he underwent two cervical fusions. There was also evidence of early myelopathy. At the time he was evaluated by respondent he had complaints of increasing pain in his neck associated with pain radiating to both arms. He had associated posterior occipital headaches, increasing weakness in the hands, left worse than the right, numbness/tingling in both hands and increasing weakness in his left leg.

Findings on physical examination included bilaterally depressed triceps reflex, and lower extremities revealed hyperreflexia with the left patella more than the right. An MRI was attempted and found to be unclear. There were only degenerative changes at the C3-4 level and everything else was obscured. Respondent's diagnosis was acute C6-7 radicular irritation; evidence of early myelopathy with spasticity and hyperreflexia in the lower extremities and evidence of C6 cervical radiculopathy. L.W. was hospitalized between February 10 – 15, 1997, and placed on continuous traction. Improvement of his symptoms was noted.

20. L.W. was admitted to the hospital on two subsequent occasions:

a. August 18 – 22, 1997. L.W. was admitted because of increasing severity of neck pain radiating down both arms, posterior occipital headaches and increasing weakness of the hands, left worse than right. Examination showed bilaterally depressed triceps and increased lower extremity reflexes and slightly spastic tone. On sensory examination he had tingling in a C-6 distribution, but otherwise intact to pin prick, touch, vibration and position. Respondent's impression was acute C6-7 cervical radiculopathy. She also noted present "evidence of early myelopathy with spasticity and hyperreflexia of lower extremities." L.W. was treated conservatively with continuous traction immobilization, medication and muscle relaxants.

b. April 6 – 11, 1998. L.W. was hospitalized with complaints of increasing pain and numbness in both arms and pain in the neck radiating down both arms as well as pain on motion of the base of the head and headaches. He also had increasing weakness of his left leg. Examination showed bilaterally depressed triceps reflex, more so on the left, decreased grip strength and hyperreflexia

and spastic tone of the lower extremities. Respondent's diagnosis was acute C6-7 cervical radiculopathy and cervical myelopathy. L.W. was treated conservatively with continuous traction, immobilization, relief with analgesics and muscle relaxants.

21. Dr. Miller notes that cervical myelopathy, whether early or advancing, is something of a medical emergency. This is a condition involving cord compression. It requires persistent and urgent evaluation because permanent paralysis of all extremities may result if it is left untreated. Dr. Miller points out that if the MRI was truly non-diagnostic, then a cervical myelogram would be in order. Further, he notes that acute cervical myelopathy with radiculopathy is usually a surgical condition and, accordingly, a neurosurgical consultation would have been appropriate if the etiology was not immediately clear. Dr. Miller opines that the failure to undertake further evaluation and to obtain a neurosurgical consultation is "quite significantly below the accepted standard of practice for new cervical myelopathy with radiculopathy." He characterizes her diagnostic evaluation and treatment of the putative diagnosis as being extreme departures from the standard of care, or gross negligence.

In any case, Dr. Miller notes that cervical traction is not the treatment for advancing cervical myelopathy, with or without cervical radiculopathy. If one is concerned about an unstable neck there is a role for cervical stabilization until definitive surgical management can be undertaken, but this was not the nature of the traction applied by respondent. The use of traction is not a big deal if a chronic process was involved, and it will not hurt the patient. But Dr. Miller points out that it was respondent who characterized the cervical myelopathy as "early", and if that was the case the failure to go after it aggressively was, he believes, inexcusable.

22. Respondent avers that she never treated L.W. for acute myelopathy because he never had that condition. She disputes Dr. Miller's reference to L.W. having Lhermitte's sign, a sharp tingling sensation of shock from the head downward. She avers L.W. never had that. Rather, she states that L.W. was treated for cervical spondylitic findings. Her reference to myelopathy was intended to evidence cord involvement and spasticity, not an acute condition, although he may have had some cervical irritation. She found no evidence of paralysis or progressive weakness. Given the presenting symptoms, she believes that her treatment of L.W. was appropriate. The cervical traction was very little, only two pounds, and she suggests it was basically to keep him in bed. She points to the fact that he was working and walking as evidence that the treatment made him more comfortable and caused him no harm.

23. Patient M.P. This 30-year old male was hospitalized on November 30, 1990, with a history of having been involved seven months earlier in an automobile accident. He was experiencing increasing, severe, lower back pain radiating down to his right thigh and calf. A lumbar MRI performed on August 29, 1990 revealed moderate L4-5 disc herniation with effacement of the anterior aspect of the thecal sac, with mild secondary central canal stenosis. At the L5-S1 level he also had a mild right paracentral disc protrusion with some

pressure on the right S1 nerve root. Respondent's impression at that time was acute L5-S1 lumbar radiculopathy on the right. He was treated through December 6, 1990, after being placed on complete bed rest, with traction and immobilization, and muscle relaxants and pain medication.

M.P. was hospitalized again between May 1 and May 5, 1995. He was now age 34 and complaining of increasing severe, excruciating back pain radiating to both buttocks and to the right thigh and calf. Respondent related his symptoms back to the April 1990 motor vehicle accident and admitted him for further conservative treatment. Examination by respondent showed paralumbar spasm and tenderness at L4-5, positive straight leg raisingand decreased knee-jerk and absent right ankle jerk. There was weakness of the EHL. A May 3, 1995 MRI revealed a right L4-5 disc herniation with extrusion and other herniation extending within the right neural foramen at L4-5. M.B. was placed on continuous traction. Upon discharge he was referred by respondent to Brian Andrews, M.D. for neurosurgical consultation as an outpatient for probable decompression. Dr. Andrews performed a microlumbar discectomy, L4-5 on the right, on June 7, 1995.

24. Dr. Miller opines that treating M.P., with bed rest/traction was inappropriate and below the standard of care. He also faults respondent for failing to obtain a timely consultation. Dr. Miller believes that given the findings described by respondent and the May 3, 1995 MRI report, neurosurgical evaluation at that time would have been indicated, rather than as an outpatient referral.

Respondent did refer M.P. for surgery and such referral was both appropriate and timely, the surgery having been performed by June 7.

25. Patient C.S. This 55-year old woman came under respondent's care in March 1997 with complaints of back pain following a fall in October 1996 down a flight of stairs. The pain had become progressively worse to the point where she was no longer able to manage. Examination showed right paralumbar muscle spasms and tenderness, bilaterally positive straight leg raising, depressed right ankle and knee jerk and right EHL and leg weakness. Sensory examination showed tingling in the L5 distribution. Lumbar and cervical MRI showed marked facet hypertrophy with mild central canal stenosis at L2-3 and L3-4, and spondylotic irregularities, some facet hypertrophy and degenerative changes in the cervical spine. Respondent diagnosed C.S. with acute L4-5 lumbar radiculopathy on the right. She was hospitalized March 24 – 29, 1997, and treated conservatively with continuous traction and immobilization, analgesics and muscle relaxants.

26. Respondent hospitalized C.S. on six subsequent occasions, ending in May 1998, all prompted by what respondent characterizes as acute exacerbation of symptoms caused by precipitating factors. Respondent prepared a summary of clinical course for C.S. and identified precipitating factors, apart from a November 1997 auto accident, as:

> House work. She had also to take care of her daughter's out of wedlock baby who had intestinal atresis and had numerous operations. She also had to take care of her

husband who was totally disabled with a very bad neck and back. She did all the housework, cleaning, cooking and taking care of the baby as well as her two daughters.

Respondent notes that C.S. was evaluated by a neurosurgeon and an orthopedist and declared a non-surgical candidate due to the extensive nature of degenerative changes and epidural fibrosis. She describes her condition as "severe cervical and lumbar spondylosis with epidural scarring."

27. A summary of the six hospital admissions and treatment received follows:

a. May 5 – 10, 1997. C.S. was admitted because of increasing severity of her back pain and inability to manage at home. Similar findings on examination were noted and she was diagnosed with acute L5-S1 lumbar radiculopathy. She was treated with continuous traction and immobilization, analgesia and muscle relaxants. Upon discharge she was to be followed by respondent and have outpatient physical therapy.

b. June 16 – 20, 1997. C.S. was admitted due to increasing severity of her pain and inability to walk and manage at home. She had an MRI that revealed moderate to marked facet hypertrophy and narrowing of both neural foramina at L4-5 and L3-4 levels. The diagnosis was acute L5-S1 lumbar radiculopathy bilateral. Treatment was continuous traction immobilization, medication and muscle relaxants, to be followed by outpatient physical therapy.

c. September 15 – 19, 1997. C.S. was admitted due to increasing severity of symptoms and inability to manage at home. Findings on examination included tenderness of the neck and back, positive straight leg raising bilaterally, depressed ankle and knee jerks on the right and weakness of the left EHL. The diagnosis was acute L5-S1 lumbar radiculopathy bilaterally, left greater than right and acute cervical radiculopathy C6-7, left greater than right. C.S. was treated conservatively with continuous traction, immobilization, medication and muscle relaxants.

d. December 8 – 13, 1997. C.S. was hospitalized due to increasing severity of symptoms and inability to manage at home. She had had a November automobile accident followed by increasing neck and back pain. A cervical spine x-ray showed hypertrophic spurring at multiple levels from C3-T1 with disc space narrowing. Diagnoses included acute C6 cervical radiculopathy, right greater than left, and acute L5-S1 radiculopathy, right greater than left. C.S. was treated as before with continuous traction, immobilization and analgesics.

e. March 9 – 12, 1998. C.S. was admitted due to increasing severity of symptoms and inability to manage at home. She had fallen the day previous. Examination showed pain on motion in the neck in every direction, positive straight leg raising, depressed right knee and ankle jerks and weakness of both EHL. Respondent diagnosed C.S. with acute cervical C6 cervical radiculopathy, bilaterally, right greater than left, and acute L5-S1 lumbar radiculopathy. She was treated with continuous traction, immobilization, intramuscular medications and muscle relaxants.

f. May 4 – 9, 1998. C.S. was admitted following a fall down a flight of stairs. She complained of several attacks of severe pain in the neck radiating down both arms, and severe sharp, stabbing lower back pain radiating down both buttocks, especially down the left thigh and calf. Examination showed positive leg raising, muscle spasm, depressed knee and ankle jerks and weakness of the left EHL. Respondent's impression was acute L5-S1 lumbar radiculopathy, left greater than right, and acute C6 cervical radiculopathy, left greater than right. Treatment consisted of continuous traction, immobilization, intramuscular medications and muscle relaxants.

28. Dr. Miller finds many similarities in respondent's treatment of patients A.S. and C.S. He points out that "acute" means new and not severe, that multi-level radiculopathy is quite unusual and that there are other causes of persistent neck and back pain than radiculopathy. In this case he notes that imaging showed facet arthropathy, a form of arthritis known to produce a picture most compatible with the symptoms described by C.S. Dr. Miller also suggests that recurrent events such as falling down stairs are medically alarming and might indicate further evaluation for such processes as peripheral neuropathy, visual abnormalities, substance or spousal abuse. He opines that her failure to assess these possibilities, and her treatment of neck and back pain with bed rest and traction, are below contemporary standards of care. In this case Dr. Miller would recommend that she be prescribed oral analgesics, specifically anti-inflammatory medications, with graduation to narcotics if the former is not helpful. Other treatment options would include facet injections with fluoroscopic guidance, or finally denervating facet joints (rhizotomy) if pain cannot otherwise be controlled.

Respondent disagrees. She notes that facet blocks are extremely painful and that there are side effects to rhizotomy. She did not view C.S. as a candidate for any type of surgery. Respondent also insists that C.S. was more than adequately worked up, that all her findings were consistent with MRI findings, and that conservative treatment was both appropriate and effective in alleviating her pain and discomfort.

29. Patient A.H. This individual was hospitalized twenty (20) different times over a period of three years, and each time his treatment consisted of bed rest, traction and medications. He first injured his lower back and neck during an industrial accident in 1985. The twenty hospital admissions were between September 1993 and May 1996 and are summarized briefly below:

a. September 9 – 13, 1993. A.H. was age 58 at the time of his admission for "acute onset of back and neck pain." The day previous he had fallen backwards while sitting, striking his left elbow and backside, and snapping his neck. Examination showed neck and low back tenderness and trapezius muscle spasm, depressed right biceps and triceps reflex, bilaterally positive straight leg raising, diminished right knee and ankle jerk, weak right side EHL, and decreased right lateral thigh L5/S1 sensation to pinprick. He was diagnosed with acute cervical lumbar sprain, acute lumbar L5-S1 radiculopathy on the right, acute C5-6 cervical irritation, diabetes mellitus. Treatment consisted of continuous traction immobilization, intramuscular medications and muscle relaxants.

b. October 20 – 25, 1993. A.H. was admitted with acute neck and back pain relating back to the September fall, and with complaints of increasing symptoms and inability to manage at home. The neck and low back were tender and straight leg raising was positive bilaterally. Right knee and ankle jerks were depressed and the right EHL was weak. He was diagnosed with acute cervical and lumbosacral sprain, acute C5-6 cervical radiculopathy, acute L5-S1 level radiculopathy right greater than left. Treatment was continuous traction and immobilization, intramuscular medications and muscle relaxants.

c. February 3 – 7, 1994. A.H. was involved in a motor vehicle accident and developed increasing pain radiating to both arms with pain on motion of the neck, and severe lower back pain radiating to the left buttocks, thigh. MRI imaging revealed C3-4 disc herniation on the right with bilateral foraminal stenosis at C5-6 and C6-7 with posterior osteophytes. His diagnoses included acute cervical lumbar sprain, acute cervical C6-7 radiculopathy and acute lumbar L5-S1 radiculopathy. He was hospitalized and treated conservatively with continuous traction, immobilization, intramuscular medications and muscle relaxants.

d. April 13 – 18, 1994. A.H. was admitted with severe neck pain/discomfort and inability to manage at home. A March 22 MRI indicated chronic cervical disc degeneration and spondylosis; advancing from C4 through C7. An April 13 cervical MRI showed marked degenerative spondylosis with narrowing of the AP diameter of the central canal progressing to the C3-4 level. Respondent diagnosed him with acute C5-6 and C6-7 cervical radiculopathy and cervical spondylosis. He was treated as before with traction, immobilization, medications and muscle relaxants.

e. May 11 – 16, 1994. A.H. was admitted with "acute neck and back pain." He was diagnosed with acute C6-7 and C5-6 cervical radiculopathy, cervical spondylosis, and acute L5-S1 lumbar radiculopathy left greater than right. Treatment consisted of bed rest, traction and medication.

f. June 13 – 18, 1994. He was admitted with "acute neck and back pain." Respondent noted increasing severity of his neurological symptoms, failure of conservative treatment and inability to manage at home. She diagnosed him with 1) acute C5-6 and C6-7 cervical radiculopathy, 2) acute L5-S1 lumbar radiculopathy, right greater than left, and 3) cervical spondylosis. He was treated with continuous traction immobilization, medications and muscle relaxants.

g. August 10 – 15, 1994. A.H. was admitted with "acute neck and back pain." His diagnosis was acute C6-7, C5-6 cervical radiculopathy left greater than right, cervical spondylosis, cervical stenosis, and acute L5-S1 lumbar radiculopathy left greater than right. Treatment was continuous traction, immobilization, medications and muscle relaxants.

h. September 24 – 30, 1994. A.H. was admitted with "acute neck and back pain" following a fall. Respondent diagnosed him with "[a]cute C5-6 and C6-7 radiculopathy; acute lumbar sprain, acute L5-S1 lumbar radiculopathy; minimal diabetic neuropathy and cervical spondylosis." She ordered bed rest, traction and medications.

i. December 8 – 13, 1994. This admission was for acute neck and back pain with increasing severity of symptoms and inability to manage at home. He was treated with six days bed rest and traction and medications for a diagnosis of "[a]cute C6-7 cervical radiculopathy, acute L5-S1 radicular pain, cervical spondylosis, cervical canal stenosis, lumbar radiculopathy L5-S1, diabetes mellitus."

j. February 15 – 20, 1995. A.H. was admitted with severe neck pain radiating down both arms. He was diagnosed with acute C5-6 and C6-7 cervical radiculopathy and cervical spondylosis. Treatment consisted of continuous traction, immobilization, medications and muscle relaxants.

k. April 3 – 9, 1995. A.H. was admitted for "acute neck and back pain." He was diagnosed with acute cervical and lumbar radiculopathy. Treatment was as before.

l. June 5 – 10, 1995. A.H. was admitted with "acute neck and back pain." Diagnosis and treatment were as before.

m. July 10 – 15, 1995. A.H. was admitted with acute pain in the neck and lower back. Diagnosis was acute cervical radiculopathy and acute lumbar radiculopathy. Treatment consisted of bed rest, traction and medications.

n. August 14 – 19, 1995. He was admitted with acute severe neck pain aggravated by neck motion radiating to the left arm and forearm. Respondent diagnosed him with acute cervical C6-7 radiculopathy and cervical spondylosis. He received continuos traction, immobilization and muscle relaxants.

o. September 25 – 30, 1995. A.H. was admitted with acute neck pain radiating down both arms with associated numbness and tingling in his fingers. Diagnosis was acute C6-7 cervical radiculopathy, cervical spondylosis and acute L5-S1 lumbar radiculopathy. Treatment was as before.

p. December 12 – 15, 1995. A.H. was admitted with acute onset of neck pain radiating down both arms, and severe low back pain. Respondent's diagnosis was acute C6 cervical radiculopathy and acute L5-S1 lumbar radiculopathy. A.H. was treated with bed rest, traction, medications and muscle relaxants.

q. January 29 – February 3, 1996. A.H. was admitted with "acute neck and back pain." Diagnosis was acute C6 cervical radiculopathy, right greater than left, acute L5-S1 lumbar radiculopathy, right greater than left, cervical spondylosis of cervical and lumbar disc. He was treated conservatively with continuous traction, immobilization, intramuscular medications and muscle relaxants.

r. March 11 – 16, 1996. This admission was for "acute neck and back pain." He had been seen by a neurosurgeon who recommended cervical compression with fusion, but A.H. opted for conservative treatment. He was diagnoses with acute C6-7 cervical radiculopathy, acute L5-S1 lumbar radiculopathy. Treatment was as before.

s. April 10 – 14, 1996. He was admitted with "acute back pain radiating down his left leg." The diagnosis was acute L5-S1 lumbar radiculopathy and he was treated as before.

t. May 13 – 19, 1996. This is the last hospital admission referenced for A.H. He was admitted with acute onset of back pain radiating to the right thigh and calf, more so than left. Findings included depressed left triceps reflex, low back tenderness and spasm with bilaterally positive straight leg raising, depressed right ankle jerk, weak bilateral EHL, and sensory loss in the left leg L5 distribution along with sensory loss of peripheral neuropathy. Diagnosis was acute C5-6, C6-7 cervical radiculopathy and acute L5-S1 lumbar radiculopathy, right greater than left. He was treated with bed rest, traction and medications as before.

30. A.H. had 20 hospital admissions in less than three years. Dr. Miller notes that such a frequency of admission to hospitals is "really quite extraordinary and should have suggested to Dr. Dramov that what she was doing wasn't working." He faults her for not

referring A.H. to a physician with up to date knowledge about pain assessment and treatment. He believes that had such a referral been made, in addition to pharmacological management, anesthetic interventions such as facet or epidural injections would have been suggested. Other issues raised by Dr. Miller include "the diagnosis of multiple, concurrent, acute radiculopathies as a reasonable diagnosis; the failure to produce a reasonable differential diagnosis; and a lack of dependable physical examination which finds reflexes that tend to come and go over time and sensory changes that change likewise." He opines that she departed from the standard of practice in this case, as in previous cases, for the treatment of "radiculopathy" or neck and back pain with traction and bed rest. Dr. Miller attributes this to her failure to stay abreast of medical knowledge.

Respondent believes that MRI findings correlate with her clinical examination and her diagnosis of radiculopathy at two levels. She notes that A.H. is a very heavy man and a difficult case. He was seen by an orthopedist and by a neurosurgeon and that they both felt that his condition was inoperable given his weight and multi-level involvement. A.H. also refused surgery leaving conservative therapy as the primary means of management when his pain became unbearable. He did improve over time and he is currently employed as a security guard.

31. Patient M.F. Between February 1993 and January 1996, M.F. had twelve (12) hospital admissions relating to complaints of neck and/or back pain. Respondent treated her conservatively in each instance with bed rest, traction and medications. The hospital admissions are summarized below:

a. February 17 – 25, 1993. At the time of this admission M.F. was age 52. She had fallen on her back four days previous and developed sharp acute back pain and spasms radiating across both buttocks and thighs. She also developed sharp pain in the neck radiating to the left arm, and associated with numbness in the left forearm. Left biceps and triceps reflexes were depressed, straight leg raising was positive bilaterally, left knee and ankle jerks were depressed, as was sensation of the left forearm (C6-7) and left calf (L5-S1). Respondent's diagnosis was acute cervical lumbar spine, acute L5-S1 radiculopathy, left greater than right, acute cervical radiculopathy, C5-6 and hypertension. She was treated conservatively with traction and immobilization, intramuscular medication and muscle relaxants.

b. May 10 – 17, 1993. M.F. was admitted due to progression of symptoms relating to the previous fall and because of her inability to manage at home. Her diagnosis was acute C6 cervical radiculopathy on the left, acute L5-S1 radiculopathy left greater than right, and acute cervical lumbar sprain. While in the hospital she was treated with bed rest and continuous traction, as well as muscle relaxants and heat.

c. November 11 – 15, 1993. M.F. was admitted after falling on her lower back a few weeks prior to admission. She developed progressively severe lower back pain radiating to both buttocks and thighs and was admitted due to inability to manage at home and inability to put weight on her leg. Respondent's impression was acute lumbosacral pain secondary to acute fall, and acute L5-S1 lumbar radiculopathy left greater than right. Treatment consisted of continuous traction, immobilization, intramuscular medications and muscle relaxants.

d. February 24 – March 1, 1994. M.F.'s left leg gave out at home resulting in a fall several weeks prior to admission. She reported increasing symptoms of very sharp stabbing burning back pain radiating to both buttocks, and especially to the left thigh and calf posteriorly. Respondent's impression was acute L5-S1 lumbar sprain, acute L5-S1 lumbar radiculopathy on the left, herniated nucleus pulposus L4-5. She received traction, immobilization, intramuscular medications and muscle relaxants.

e. June 6 – 16, 1994. M.F. fell three weeks prior to admission. She was admitted with complaints of back pain and inability to manage at home. Respondent's diagnosis was acute lumbar radiculopathy L5-S1, acute lumbar sprain, and multiple bruises from fall. She was treated with continuous traction, immobilization and muscle relaxants.

f. September 22 – 29, 1994. M.F. fell getting out of a shower two weeks prior to admission. She was admitted with complaints of back pain, inability to manage at home and increasing weakness and severity of symptoms. Her diagnosis was acute cervical lumbar sprain, acute L5-S1 lumbar radiculopathy, and C5-6 cervical radicular pain. She was treated with continuous traction and immobilization, intramuscular medications, muscle relaxants and heat.

g. November 2 – 9, 1994. M.F. fell three weeks prior to admission. She developed neck and back pain and was admitted due to progression and aggravation of her symptoms. Respondent's diagnosis was acute cervical lumbar sprain, acute C5-6 cervical radiculopathy, and acute L5-S1 lumbar radiculopathy. She was treated with continuous immobilization and traction of both cervical and lumbar, intramuscular medication, analgesics and heat.

h. June 5 – 10, 1995. M.F. fell a week and a half prior to admission, striking her lower back. MRI of the lumbar spine revealed an L4-5 herniated disc. She was diagnosed with acute L5-S1 lumbar radiculopathy and treated as before with continuous traction, bed rest and muscle relaxants.

i. September 11 – 15, 1995. M.F. fell three weeks prior to admission and had complaints of back pain. She could not put weight on her left leg, she was unable to manage at home and her symptoms progressed. Her diagnosis was

acute lumbosacral sprain and acute L5-S1 lumbar radiculopathy. She was treated with traction, medications and bed rest.

j. October 23 – 28, 1995. M.F. fell several weeks prior to admission and had complaints of back pain. The diagnosis was acute L5-S1 lumbar radiculopathy secondary to fall at home; acute shoulder, cervical and lumbosacral strain. She was treated as before with continuous traction, immobilization, intramuscular medications and muscle relaxants.

k. November 13 – 18, 1995. M.F. fell two weeks prior to admission striking her lower back on the left side. Respondent's diagnosis was acute L5-S1 lumbar radiculopathy. She was treated with continuous traction, immobilization, intramuscular medications and muscle relaxants.

l. January 29 – February 3, 1996. This is the last of the hospital admissions referenced. M.F. fell one week prior to admission and was complaining of severe, acute, sharp, stabbing pain radiating down both thighs and calf muscles, more so on the left. She was diagnosed with acute L5-S1 lumbar radiculopathy and treated with continuous traction, immobilization, intramuscular medications and muscle relaxants.

32. Dr. Miller opines, as before, that treatment of neck and back pain by bed rest, traction and the medications prescribed in this case was inappropriate. He has additional concerns that the repeated falls were not addressed, that the series of twelve hospital admissions suggest that the treatment was ineffective, and that other treatment modalities should have been considered.

Respondent believes she did address the frequent falls. She attributes them to the fact that M.F. was nearly 300 pounds and that her left knee often gave out under her. An orthopedist had suggested that she have a total knee replacement but she had refused. When she did fall it would trigger "acute severe pain" in her back that would improve with the treatment she received. Because of her weight M.F. was not considered a candidate for surgery.

33. Discussion.

Complainant alleges that respondent committed repeated negligent acts and/or demonstrated a lack of knowledge or ability in the care of these seven patients. It was established that her treatment of these patients repeatedly fell below the standard of practice. There was competent medical expert testimony that hospital admission for treatment of neck and back pain with bed rest and traction is no longer the standard of care. It is sub-optimal and it may even be deleterious if prolonged bed rest leads to de-conditioning effects, muscle loss and cardiovascular decline. (Finding 9.) Alternative therapies were available and although respondent was aware of them she was quick to rule them out for the reasons already noted. (Finding 12.) The standard of practice for treatment of back and neck pain

must include consideration of a broader array of outpatient therapies. These include everything from physical therapy, oral analgesics (NSAID) and oral narcotics, to more aggressive measures such as facet joint or epidural injections for management of pain. Respondent also persisted in utilizing bed rest and traction despite evidence that multiple hospitalizations, twenty in the case of A.H., for treatment with these modalities had been relatively ineffective.

Respondent seemed almost fixated on diagnosing radiculopathy, a relatively rare cause of neck and back pain. In doing so she failed to consider other more common causes for her patients' neck and/or back pain such as cervical and lumbar arthropathy leading to arthritis-type pain. (Finding 10.) There were also issues around her not making differential diagnoses and her finding multi-level radiculopathy, a rather exceptional occurrence. Taken together her actions suggest a lack of knowledge and ability in assessing the causes of neck and back pain, and of currently accepted treatment modalities for treatment of patients with chronic neck and/or back pain. Her lack of understanding of neck and back disease processes may explain her persistent attribution of related pain to radiculopathy, and her omission of other more reasonable diagnoses. The expert medical testimony and opinions offered by Dr. Miller on these points were determined to be most persuasive and reflective of current medical thinking and practice in these areas.

34. Complainant also alleges that respondent was grossly negligent in her care of L.W. She is charged with failing to conduct a standard of care evaluation for cervical myelopathy (cord compression), which is a serious and potentially disabling condition, with ordering inappropriate treatment for cervical myelopathy and with failing to obtain appropriate tests and/or surgical consultations for cervical myelopathy. (Finding 21.)

In fact, it does not appear that L.W. presented to respondent with cervical myelopathy. (Finding 22.) Respondent avers that her reference to myelopathy was intended to connote cord involvement and spasticity, and not to any acute condition. There was no evidence of paralysis or progressive weakness, only some cervical irritation. The confusion obviously relates to her failure to correctly state her diagnostic findings. She diagnosed L.W. with "acute C6-7 cervical radiculopathy" and this was inaccurate. Her failure to correctly state her diagnosis is a departure from the standard of care, or simple negligence. Such departure was not so extreme as to constitute gross negligence.

35. Complainant recommends that respondent participate in a rehabilitation program that emphasizes medical education. Respondent needs remedial medical education that addresses the issues raised by this case. She has an adequate medical knowledge base but would clearly benefit from a course of training designed to address gaps in her knowledge and to update her medical education and training. The University of California San Diego Medical School has such a program. Under this or other similar program a panel of objective physicians evaluates program participants and recommends a course of training designed to bring a physician's medical training and knowledge up to date. It is recommended that respondent participate in such a program as a condition of probation.

36. Investigation/Enforcement Costs. The following costs were incurred by the Board in connection with the investigation and prosecution of this case:

Board Investigative Services

7/98 – 12/99	4 hrs.	$108.80/hr.	$ 489.60
1/99 – 6/99	17	103.07	1,752.19
7/99 – 12/99	10	103.07	1,030.70
7/01 – 12/01	4	110.84	443.36

Expert Reviewer Services

Report Review and writing: 32 hrs. @ $75/hr.	$2,400.00
Total Board Costs:	$6,115.85

Attorney General Costs

1999 – 2000	64 hrs.	$100/hr.	$6,400.00
2000 – 2001	77.75	106	8,241.50
2001 – 2002	143.00	112	16,016.00
		Total Attorney General Costs:	$30,657.50

Certification of cost declarations for the above costs were reviewed and it is determined that these costs are reasonable. The total incurred by the Board in connection with the investigation and prosecution of this case is $36,773.35.

LEGAL CONCLUSIONS

1. Respondent moves to dismiss the Accusation on the grounds that complainant has not satisfied elements of the causes of action. Specifically, respondent argues that the California Superior Court has already determined that respondent's conduct did not endanger the health of any of the patients at issue in this case and therefore an element of the causes of action for negligence and gross negligence remains unsatisfied. The Superior Court made a specific finding that there was no substantial evidence to support the claim of St. Mary's Hospital that respondent's conduct even endangered her patients. These included all the patients referenced in this case.

Injury or harm to a patient is not required before disciplinary action can be taken by the Board. (*Kearl* v. *Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040.) In *Kearl*, an anesthesiologist challenged a finding of gross negligence on the basis that no patient harm resulted from his failure to record vital signs at five-minute intervals. He argued that to find him grossly negligent in his recordation was to assert form over substance. The Appellate Court rejected this contention holding:

> Business and Professions Code section 2234 does not limit gross negligence or unprofessional conduct to the actual treatment of a patient – as opposed to administrative work – and does not require injury or harm to the patient before action may be taken against the physician or surgeon.

Even where a patient ultimately does well, a licensee may be disciplined for unprofessional conduct. (*Hongsathatvij* v. *Queen of Angels* (1998) 62 Cal.App.4th 1123, 1139.)

In this case there was competent evidence that respondent's treatment was both substandard and potentially harmful to her patients. Dr. Miller opined that prolonged bed rest contributes to de-conditioning, muscle loss and cardiovascular decline, and he also identified other generally accepted and alternative treatments that were available. These included physical therapy, medications and other interventions short of hospitalization. Respondent's failure to employ alternative treatments, or to refer patients to others more familiar with such treatments, may have endangered their health.

The Board is not precluded by the doctrines of collateral estoppel or res judicata from pursuing this disciplinary action. The issues raised in this case relate to the standard of care for treatment of back and neck complaints, whereas the hospital proceedings arose from issues related to unnecessary hospital admissions. Respondent has not demonstrated that privity exists between St. Mary's Medical Center and the Board. Privity between parties requires that the non-party has an identity of interest with, and adequate representation by, the party in the first action and the non-party should reasonably expect to be bound by the prior adjudication. (*Helfand* v. *National Union Fire Insurance* (1992) 10 Cal.App.4th 869, 902.) Courts have refused to apply the doctrine unless the relationship between the party and the non-party is a close one. (*Victa* v. *Merle Norman Cosmetics, Inc.* (1993) 19 Cal.App.4th 454, *People* v. *Meredith* (1992) 11 Cal.App.4th 1548.)

The objectives of St. Mary's Hospital and the Board are not identical. The Medical Board is statutorily obligated to make protection of the public its highest priority. (Bus. & Prof. Code, § 2229.) St. Mary's Hospital had other concerns including the necessity and financial impact of respondent's many hospital admissions. A hospital's review of a physician's actions is institution specific and not necessarily directed to the protection of the public. (*Arnett* v. *Dal Cielo* (1996) 14 Cal.4th 4, 12.) The Supreme Court in *Arnett* noted important differences between the Board and hospital peer review committees. The Board is a public agency created and funded by the state. It employs independent investigators. Peer review committees are composed of private physicians selected by and from the staff of a hospital. The conduct of errant physicians is not reviewed by "independent, professional investigators, but by the physician's own colleagues practicing in the same hospital." (*Ibid.*) Although there is an overlapping public protection function, peer review also serves the private role of reducing the exposure of the hospital to potential tort liability. The Supreme Court emphasized the institution specific role of hospital peer review committees:

> The "public" protected by the peer review process is not the public at large, but is limited to the patients of the particular hospital in question. The process is institution specific: a physician stripped of staff privileges by one hospital is not ipso facto prevented from obtaining or maintaining such privileges at other hospitals – the only entity with the power to prevent that from happening is the Board.

(*Ibid.* Footnotes omitted.)

For all these reasons respondent's motion to dismiss the Accusation is denied.

2. Under Business and Professions Code section 2234 the Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes gross negligence, repeated negligent acts or incompetence. (Bus. & Prof. Code, § 2234, subds. (b), (c) and (d).)

3. No cause exists for disciplinary action against respondent under Business and Professions Code section 2234, subdivision (b), by reason of the matters set forth in Findings 22 and 34. Respondent's failure to provide an accurate diagnosis for L.W. was below the standard of care, or simple negligence, but it did not constitute gross negligence.

4. Cause exists for disciplinary action against respondent under Business and Professions Code section 2234, subdivisions (c) and (d), by reason of the matters set forth in Finding 33. Respondent demonstrated repeated acts of negligence and incompetence in her treatment of the seven patients referenced in this case. (See Findings 7 – 32.)

5. Under Business and Professions Code section 125.3 the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of this case. Reasonable costs are determined in this case to be $36,773.35 by reason of the matters set forth in Finding 36.

6. It would not be contrary to the public interest, health or safety for respondent to be issued a probationary license at this time, one of the terms of probation being that she participate in a medical education program as described in Finding 35.

ORDER

Physician's and Surgeon's Certificate No. G 11513 issued to Borina Dramov, M.D. is revoked. However, revocation is stayed and respondent is placed on probation for four (4) years upon the following terms and conditions. Within fifteen (15) days after the effective date of this decision respondent shall provide the Division, or its designee, proof of service that respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent or at any other facility where respondent engages in the practice of medicine and

on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to respondent.

1. Clinical Training Program. Within ninety (90) days of the effective date of this decision, respondent shall submit to the Division or its designee for prior approval, a clinical training or education program such as the Physician Assessment and Clinical Education Program (PACE) offered by the University of California San Diego School of Medicine or equivalent program as approved by the Division or its designee. The exact number of hours and specific content of the program shall be determined by the Division or its designee.

Respondent shall successfully complete the training program and shall comply with the clinical training program recommendations and may be required to pass an examination administered by the Division or its designee related to the program's contents. Respondent shall pay the costs of all clinical training or educational programs.

2. Obey All Laws. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments and other orders.

3. Quarterly Reports. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

4. Probation Surveillance Program Compliance. Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of her addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall, at all times, maintain a current and renewed physician's and surgeon's license.

Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

5. Interview with the Division. Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

6. Tolling of Probation. In the event respondent should leave California to reside or practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the Division or its designee in writing within ten (10) days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty (30) days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary order.

7. Violation of Probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

8. Cost Recovery. Respondent is hereby ordered to reimburse the Division the amount of $36,773.35 within ninety (90) days from the effective date of this decision for its investigative costs. Failure to reimburse the Division's cost of its investigation shall constitute a violation of the probation order, unless the Division agrees in writing to payment by an installment plan because of financial hardship. The filing of bankruptcy by respondent shall not relieve her of her responsibility to reimburse the Division for its investigative costs.

9. License Surrender. Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender her certificate to the Board. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will no longer be subject to the terms and conditions of probation.

10. Probation Monitoring Costs. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Division of Medical Quality and delivered to the designated probation surveillance monitor no later than January 31 of each calendar year. Failure to pay costs within thirty (30) days of the due date shall constitute a violation of probation.

11. Completion of Probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

DATED: 2/8/62

JONATHAN LEW
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: BORINA DRAMOV, M.D. 2107 Van Ness Avenue, Suite 100 San Francisco, CA 94109 Physician's and Surgeon's Certificate No. G 11513 Respondent.	Case No. 03 1998 88144 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Ron Joseph ("Complainant") brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about December 20, 1965, the Medical Board of California issued Physician's and Surgeon's Certificate Number G 11513 to Borina Dramov, M.D. ("Respondent"). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2002, unless renewed.

JURISDICTION

3. This Accusation is brought before the Division of Medical Quality, Medical Board of California ("Division"), under the authority of the following sections of the

Business and Professions Code ("Code").

4. Section 2004 of the Code states:

The Division of Medical Quality shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a medical quality review committee, the division, or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

6. Section 2234 of the Code states that the Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate.

(g) The practice of medicine from this state into another state or country without

meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

7. Section 125.3 of the states, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

8. Welfare and Institutions Code section 14124.12 provides, in pertinent part, that:

(a) No funds appropriated by this act may be expended to pay any Medi-Cal claim for any service performed by a physician while that physician's license is under suspension or revocation due to a disciplinary action of the medical Board of California; and,

(b) No funds appropriated by this act may be expended to pay any Medi-Cal claim for any surgical service or other invasive procedure performed on any Medi-Cal beneficiary by a physician if that physician has been placed on probation due to a disciplinary action of the Medical Board of California related to the performance of that specific service or procedure on any patient, except in any case where the Board makes a determination during its disciplinary process that there exist compelling circumstances that warrant continued Medi-Cal reimbursement during the probationary period.

FACTUAL ALLEGATIONS

9. Patient A.S.[1] (Medical Record no. 511404)

A. Beginning in or before June, 1993, Patient A.S., a 60 year old

1. Patient names are abbreviated to protect privacy. Full disclosure will be provided in discovery.

woman, came under respondent's care for complaints of back pain. Between June 7-16, 1993, respondent admitted Patient A.S. to St. Mary's Hospital in San Francisco, California. The reason for the admission was given by respondent as progressively increasing back pain since a fall down stairs two weeks prior. Patient A.S. was stated to have pain from the back into the left thigh and calf, increasingly worse, associated with tingling in the left thigh and calf posterolaterally. During her hospitalization, A.S. was treated with continuous traction and immobilization.

B. On June 8, 1993, a Magnetic Resonance Imaging (MRI) was performed on A.S. The radiology report described left lateral disc protrusion or subligamentous herniation at L4-5, possibly interfering with the L5 nerve root. No other disc herniations are described, but moderate generalized facet arthrosis was apparent. On June 10, 1993, Computerized Tomography (CT scan) was performed on A.S. The report of the scan stated:

> "The left-sided epidural process seen on previous MRI examination appears to represent severely advanced left L4-5 facet arthropathy with heavy calcification along spurs at the medial aspect of the facet. There also may be a small synovial cyst associated with this facet which may be impinging in the left lateral recess. These findings are causing left-sided narrowing of the canal and left L4-5 foramen. Additionally, there may be mild stenosis at L4-5."

C. Patient A.S. was again hospitalized July 14-21, 1993 by reason of increasing left leg pain and weakness and numbness in the right leg, which symptoms were attributed to her fall down stairs in or about May, 1993. The patient was again treated with bed rest, traction, intramuscular demerol and oral muscle relaxants.

D. Patient A.S. was hospitalized November 12-16, 1993 by reason of severe back pain reported to radiate into both buttocks, especially to the left thigh and calf and associated with numbness in the left thigh. Respondent's impression at that time was "Acute L5-S1 lumbar radiculopathy secondary to hernia of lumbar L4-5 disk with pressure direct pressure on the left L5 nerve root." The patient was treated with continuous traction, immobilization, intramuscular medications, muscle relaxants with reported improvement.

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E. Patient A.S. was hospitalized by respondent December 9-13, 1993 for the same complaints as led to her several previous hospitalizations, which "acute" complaints were attributed to lifting a grocery bag. Respondent's examination again revealed pain radiating posteriorly and laterally into the left thigh and calf. Her impression was: "Acute L5-S1 lumbar radiculopathy." The patient was treated with traction, immobilization, medications and muscle relaxants.

F. Patient A.S. was hospitalized July 22-27, 1994. Respondent's discharge summary indicates that the patient was admitted for treatment of "Acute cervical radicular pain, acute L5-S1 lumbar radiculopathy, acute cervical and lumbar sprain." The patient stated that she was driving her car when she was struck by a "kid on a bicycle." Her neck and back complaints were attributed to the mechanics of brake application. Examination was stated to show "spasm" of cervical trapezius muscles, right greater than left, and there was pain with any head movement. Bilateral upper extremity weakness was reported. The back was tender. Sensory leg raising was positive bilaterally. Left knee and ankle jerks were diminished, and the left leg had decreased perception to pinprick. The right lateral thigh had a sensory loss stated to be in the L5 distribution. The patient was treated with conservative continuous traction, immobilization, intramuscular medications, muscle relaxants, and heat with reported improvement.

G. Patient A.S. was hospitalized December 8-13, 1994, for back pain attributed to a fall on a wet floor. Respondent again described increasing, severe back pain and spasm radiating across both buttocks and into her left thigh and calf. She reported that the MRI performed in June 1993 demonstrated "1 mm extruded disk on L5 nerve on the left with impingement of the lateral recess at L4-5 on the left . . ." Findings on examination were similar to those on each of her prior hospitalizations and Patient A.S. was treated as before, with traction, immobilization, intramuscular medications and muscle relaxants.

H. Patient A.S. was hospitalized June 12-17, 1995, for complaints described by respondent as "acute" neck pain, right arm pain and back pain, all attributed to her recent use of a vacuum cleaner. Respondent charted that the patient had progressive, severe pain

in her neck, associated with pain down the right arm and forearm, and also associated with tingling and numbness in the right hand in a C6-C7 distribution. An MRI of the cervical spine was described by respondent as revealing severe degenerative changes and osteophytes and spurring at C5-6, C6-7, disk bulge at C5-6, osteophytes left paracentral at the C6-7 area with foraminal stenosis bilaterally, left greater than right. During her hospitalization, patient was treated with traction, immobilization, pain medications and muscle relaxants.

I. Patient A.S. was hospitalized May 13-18, 1996. Respondent's chart indicates that the patient complained of severe back pain, which radiated to the right thigh and calf. This episode was attributed to a fall and to the patient lifting her disabled mother out of bed. Respondent described the 1993 MRI to show "extruded mass of herniated nucleus pulposus in the L5 root with impingement of lateral recess of L4-5." Respondent charted an examination which demonstrated asymmetric upper and lower extremity reflexes, weakness of the right foot extensor muscles, positive straight leg raising bilaterally, a normal sensory examination and a painful gait. Her diagnosis was stated as "Acute L5-S1 radiculopathy, right more than left, right-sided." Treatment consisted of traction, immobilization, IM medications and muscle relaxants.

J. Patient A.S. was hospitalized July 8-13, 1996 for back pain attributed to the May lifting incident and fall. The patient's chief complaint was reported as back pain radiating into the left leg. Examination was stated to show a tender lower back, positive straight leg raising bilaterally, weakness of the left foot extensor muscles and decreased sensation in the L5-S1 distribution. Respondent's diagnosis was "Acute L5-S1 radiculopathy, left more so than right, and acute lumbar sprain." Treatment consisted of traction, immobilization and muscle relaxants.

10. Patient D.A. (Medical Record no. 461249)

A. Beginning in or before December 2, 1992, Patient D.A. was under respondent's care and treatment at St. Mary's Hospital in San Francisco, California. Patient D.A., a 67 year old male, had been involved in an automobile accident November 21, 1992, and was admitted to the hospital by respondent for treatment of low back and neck pain. Respondent described the back pain as radiating into both buttocks and thighs. Neck pain was said to radiate

into the shoulders, right greater than left. MRI examination of the neck and back revealed disc bulges at multiple levels and degenerative changes, but did not indicate nerve root compression, disc disease or arachnoiditis. Respondent diagnosed cervical and lumbar radiculopathies. Treatment consisted of traction, immobilization, medication and muscle relaxants.

B. Respondent admitted Patient D.A. again March 15, 1993 for "acute" low back pain resulting from the November, 1992 accident. Respondent's impression was: "Acute lumbar radiculopathy L5-S1 and L4-L5. Cervical radicular pain C6-C7." Treatment consisted of in-patient traction, immobilization, medications and muscle relaxants from March 15 through March 20. An MRI performed on March 16 showed "no evidence for spinal stenosis or disc herniation."

C. Between June 7-15, 1993, Patient D.A. was hospitalized for "acute neck and back pain; attributed to two automobile accidents (11/21/92 and 1/13/93). Pain was described by respondent as radiating to the right buttock and right thigh. Respondent's impression was: "1. Acute L5-S1 lumbar radiculopathy. 2. Cervical C6-7 radiculopathy. 3. Acute lumbar sprain." An MRI of the left hip showed osteoarthritis. Respondent treated the patient with traction, as before.

D. Respondent hospitalized the patient August 23-28, 1993. Respondent's discharge summary indicates that the patient was admitted with "acute, sharp pain radiating posteriorly to and laterally to the right thigh and calf with increasing right leg weakness." Physical examination was said to show asymmetrical reflexes in all extremities and profound extensor hallucis longus weakness, left greater than right. Straight leg raising was positive bilaterally. Her impression was: "Acute L5-S1, L4.L5 lumbar radiculopathy, right greater than left." Respondent ordered traction and immobilization.

E. Patient D.A. was admitted December 6, 1993 with "acute" neck and back pain. Respondent's summary describes increasing neck pain radiating to both shoulders, aggravated by motion of the neck. Progressively increasing sharp, stabbing back pain radiating into both buttocks, especially the left thigh and calf. The left leg was stated to have become weaker, with increasing foot drop. Respondent's impression was: "1. Acute cervical

C6-7, C5-6 radiculopathy on the right. 2. Acute L5-S1 lumbar radiculopathy, left greater than right with foot drop increasing. 3. Bradycardia. 4. Cervical spondylosis." Treatment consisted of traction, mobilization (sic), IM medications and muscle relaxants.

F. Respondent hospitalized the patient from February 23-28, 1994 by reason of "acute" neck and back pain. Neck pain was described as radiating into right shoulder, with back pain radiating into both buttocks and thighs, right greater than left. Examination was reported to show variable reflexes, left leg weakness and sensory loss. Respondent's diagnosis was: "Acute cervical lumbar sprain. Acute C5-6 and C6-7 cervical radiculopathy. Acute L4-5 lumbar radiculopathy, right greater than left." Treatment consisted of traction, immobilization and medication.

G. Patient D.A. was hospitalized June 8-13, 1994, for severe back pain "radiating to the left groin and left thigh and calf." It was stated that the patient's left leg "gave out" 1-2 times. Sensory exam reported to show decreased sensation to pinprick in left thigh, L5-S1 distribution. X-rays of the hips were performed, which showed osteoarthritis of left hip with a metallic plate and screw fixation device noted at left iliac crest. The pelvis was distorted, probably due to prior healed fracture of the pelvis. Respondent's summary states that an MRI was performed on the lumbar spine, "which revealed again foraminal narrowing on the right at L4-5, and bilaterally at L5-S1, and epidural fibrosis of L4-4 and L4-5, right greater than left." Treatment was with traction, as before.

H. Patient D.A. was hospitalized September 26-29, 1994 for low back pain resulting from bending to pick up something. Sensory examination was reported to show decreased sensation to pinprick over left thigh in L5-S1 distribution, and left calf. Physical examination was stated to show asymmetric reflexes and positive straight leg raising on the left. Treatment was provided with traction, immobilization.

I. Patient D.A. was again admitted to the hospital December 19, 1994 for "acute" back pain brought on by sitting. "He says when he got up his entire left leg gave out." Examination showed asymmetric reflexes, tender low back, positive leg raising, left greater than right and left leg weakness. Respondent's summary indicates that her impression was:

"Acute L5-S1 radiculopathy." An MRI of the patient's left hip showed moderately advanced osteoarthritis with effusion.

J. Patient D.A. was hospitalized by respondent between February 22-24, 1995, for severe low back pain radiating to the left thigh and calf and stated to be disabling to the point that he could barely walk. Respondent's impression was "Acute L5 lumbar radiculopathy." Treatment was provided with traction and immobilization, as before.

K. Respondent admitted the patient on April 24, 1995 for complaints of pain radiating into the left buttock and left leg, to point that he could barely walk, and increasing left leg weakness. Findings included asymmetric reflexes, positive straight leg raising, weak left extensor hallucis longus and quadriceps and sensory loss in the L5-S1 dermatome. Respondent's diagnosis was acute lumbar radiculopathy and arachnoiditis with increasing leg weakness, rule out recurrent disk. Treatment was with pelvic traction and medications.

L. Patient D.A. was hospitalized from July 17 through July 22, 1995 for acute low back pain radiating bilaterally into the legs, right greater than left. Respondent reported her findings on physical examination as asymmetric reflexes, tender low back, weak right anterior tibialis and left extensor hallucis longus. Her diagnosis was acute right L5-S1 radiculopathy and cervical spondylosis. Treatment was with traction and medications.

11. Patient L.W. (Medical Record no. 681850)

A. Patient L.W., a 43 year old merchant marine, came under respondent's care in or about February, 1997. At that time, L.W. had a history of an industrial injury when he was struck by an auto on the military base to which he was assigned in 1993. He was thrown with the impact and flipped, landing on his head and neck. He reported only momentary loss of consciousness, but stated that he experienced temporary quadriplegia. Two cervical fusions were performed on Guam. Respondent's summary states that there was evidence at that time of early myelopathy, with pain and numbness of both hands and pain in the neck radiating into both arms as well as pain on motion of the head, posterior occipital headaches and weakness of the left leg.

B. Respondent hospitalized L.W. at St. Mary's Hospital in San Francisco, California, from February 10 to February 15, 1997. L.W.'s complaints included increasing pain in his neck, which was associated with pain radiating to both arms. The patient reported increasing weakness in the left hand worse than the right. He also complained of both numbness and tingling in both hands as well as pain on motion of the neck turning in either direction. There was increasing weakness of left leg. Findings on physical examination included decreased triceps reflexes and increased reflexes (left patellar and ankle). Upper extremity triceps weakness was reported and lower extremity spasticity, including gait, was noted. An MRI was performed February 10, 1997, but was reported not to be useful by reason of the anatomy being obscured by surgical hardware. Respondent's diagnosis was acute C6-7 radicular irritation with evidence of early myelopathy and C6 radiculopathy. Patient L.W. was placed in continuous cervical traction.

C. Patient L.W. was again admitted to the hospital on August 18, 1997 and he was hospitalized until August 22, 1997 because of increasing severity of neck pain radiating down both arms. He also had posterior occipital headaches, aggravated by neck motion. He reported increasing weakness of the left hand, which was worse than the right. Examination showed triceps areflexia and weakness and increased lower extremity reflexes and tone. No sensory level was reported. Respondent's impression was: "Acute C6-C7 cervical radiculopathy. History of posterior subluxation of C6 on C7, with fracture of C6-7 bilaterally and evidence of early myelopathy with spasticity and hyperreflexia of lower extremities and evidence of C6 cervical radiculopathy." The patient's hospital course consisted of treatment with continuous traction, immobilization, medication and muscle relaxants.

D. Patient L.W. was admitted April 6, 1998 and hospitalized through April 11, 1998, for gradually progressing myelopathy, increasing pain and numbness in both arms and pain in the neck radiating down both arms. Also reported was pain on motion of the base of the head, increasing weakness of the left hand and reported weakness of the left leg. Flexing of his head was stated to cause pain radiating down both arms and pain in the neck area. Examination showed L'Hermitte's sign, decreased right triceps reflex and decreased grip

strength. Respondent's chart states the impression "acute C6-C7 cervical radiculopathy and cervical myelopathy." Treatment consisted of traction, immobilization, relief with analgesics and muscle relaxants.

12. Patient M.P. (Medical Record no. 465916)

A. Patient M.P. was hospitalized by respondent from May 1 to May 4, 1995. Patient M.P. had a history of an April 1990 automobile accident and November 1990 hospitalization for severe low back pain radiating to the right buttock and thigh. Lumbar MRI performed in August, 1990, was reported to show moderate L4-5 disk herniation with effacement of the anterior aspect of the thecal sac, with mild secondary central canal stenosis. At the L5-S1 level he also had a mild right paracentral disk protrusion with effacement of the epidural sac with some pressure on the right S1 nerve root. Respondent's impression as of the 1990 hospitalization was "acute L5-S1 lumbar radiculopathy on the right." Treatment at that time consisted of traction, immobilization and physical therapy.

B. Patient M.P. was admitted May 1, 1995 and hospitalized through May 4, 1995 for "increasing, severe, excruciating back [pain] radiating to both buttocks and to the right thigh and calf." Pain became unbearable and he could barely walk. Examination showed lumbar muscle spasm, positive leg raising on the right and decreased knee-jerk and absent ankle jerk on the right. There was weakness of the extensor hallucis longus. MRI showed right sided disc protrusion of slight degree centrally, but of moderate degree extending into the right neural foramen. Patient M.B. was treated with traction.

C. On June 7, 1995, the patient was again admitted and received appropriate surgical treatment from another physician in the form of microlumbar diskectomy, L4-5 on the right.

13. Patient C.S. (Medical Record no. 530818)

A. Patient C.S. came under respondent's care and treatment in or before March, 1997, when this 55 year old woman was hospitalized at St. Mary's Hospital in San Francisco, California, for treatment of "acute L5-S1 lumbar radiculopathy." The patient complained of increasingly severe back pain since a fall down stairs in October, 1996. Physical

examination was stated to show lumbar muscle spasm and tenderness, bilaterally positive straight leg raising, suppressed right ankle jerk and knee jerk, as well as right leg weakness. Sensory examination indicated a tingling in the L5 distribution. MRI examinations of the lumbar and cervical spine were performed on March 27, 1997, and showed spondylosis to those areas. Respondent treated the patient with traction, immobilization and intramuscular (IM) Demerol.

B. Patient C.S. was hospitalized by respondent May 5-10, 1997, and her stay was attributed to back pain resulting from the October, 1996 fall. Similar findings on physical examination and the same type of conservative treatment were noted, as before.

C. The patient was re-admitted and hospitalized June 16-20, 1997. A MRI examination was reported to show bony changes at L4-L5, L5-S1 consistent with facet disease. Findings on physical examination were similar to previous exams. The diagnosis was "Acute L5-S1 radiculopathy bilateral." Treatment was traction, immobilization, medication and muscle relaxants, to be followed by outpatient physical therapy.

D. Patient C.S. was admitted September 15, 1997 for increasing symptoms of back pain that prevented her from functioning at home. MRI examination was stated to show advanced degenerative changes to cervical spine. Examination showed tenderness of the neck and back, positive straight leg raising bilaterally, suppressed ankle and knee jerks on the right and weakness of the anterior tibialis. Respondent reiterated her diagnosis of "acute L5-S1 radiculopathy." Treatment consisted of traction, immobilization and medication, as before.

E. Patient C.S. was hospitalized by respondent December 8-13, 1997 for back pain attributed to the 1996 fall and a subsequent, November 1997, automobile accident. Neck pain was described as radiating into the right arm and forearm. Back pain was stated to radiate posteriorly and laterally in both buttocks and thighs, worse in the right thigh and calf. A cervical x-ray taken on December 9, 1997 showed hypertrophic spurring at multiple levels from C3 through upper T1. Respondent's impression was: "Acute C6 cervical radiculopathy, right greater than left. Acute L5-S1 radiculopathy, right greater than left." Her patient was treated with traction, immobilization and analgesics.

F. Patient C.S. was admitted March 9 and remained hospitalized

through March 12, 1998 by reason of increased back and neck pain since a fall on the day prior to admission. Examination showed "tenderness to the neck, suppressed right biceps reflex and positive straight leg raising." The impression was "Acute cervical C6 cervical [sic] radiculopathy, bilaterally, right greater than left, and acute L5-S1 lumbar radiculopathy." Treatment consisted of traction, immobilization and IM pain medications.

G. Patient C.S. was again admitted to the hospital on May 4, 1998, following a recent fall down a flight of stairs. Examination showed positive straight leg raising, muscle spasm and slight reflex asymmetries. Respondent's impression was "Acute L5-S1 lumbar radiculopathy, left greater than right. Acute C6 radiculopathy, left greater than right." Treatment consisted of traction, immobilization, IM medications and muscle relaxants.

14. Patient A.H. (Medical Record no. 596400)

A. In and before 1993, plaintiff A.H., a 57 year old diabetic male, was under respondent's care and treatment for complaints of chronic neck and back pain. As of 1993, A.H. had been hospitalized by respondent on multiple occasions for treatment with bedrest and traction. Despite the fact that the patient A.H. had not shown any long term benefit from his repeated hospitalizations, respondent continued this course of treatment and admitted A.H. to St. Mary's Hospital in San Francisco, California, for bedrest and traction on 20 occasions between September, 1993, and May, 1996.

B. On September 9, 1993, Patient A.H. was admitted after he fell during an attempt to sit in a chair. Respondent's discharge summary, which was dictated six weeks later, states that the patient had an "acute onset of back and neck pain" even though he had been treated by respondent for these complaints on multiple prior occasions. Examination was stated to demonstrate tenderness and spasm to the neck and trapezius. Right biceps and triceps reflexes were depressed and pain was reported to radiate from the low back into the left buttock and thigh, as well as the right calf. Sensory loss to the right lateral thigh was also reported. Respondent's diagnosis was "acute cervical lumbar sprain, acute lumbar L5-S1 radiculopathy on the right, acute C5-6 cervical irritation, diabetes mellitus." Patient A.H. was treated five days with in-patient bedrest, traction and IM pain medications.

C. On October 20, 1993, Patient A.H. was admitted after he fell "when a chair while he was trying to sit at Laguna Honda Nursing Home broke . . ." Respondent's discharge summary states that outpatient treatment was provided "with no relief" and low back pain was stated to radiate across both buttocks and thighs and down the right thigh and calf posteriorly. Sensation in the right thigh L5 distribution and right calf S1 distribution was diminished. Neck pain was reported to radiate into the left arm and forearm. Treatment was five days inpatient bedrest and traction for a diagnosis of "acute cervical and lumbosacral sprain, acute C5-C6 cervical radiculopathy, acute L5-S1 level radiculopathy right greater than left, hypertension controlled, and diabetes mellitus."

D. On February 3, 1994, Patient A.H. was admitted to the St. Mary's Hospital after he was involved in a rear-end motor vehicle collision. The patient was admitted after conservative treatment at home only resulted in stabbing neck and back pain. Respondent diagnosed the patient with "acute cervical and lumbar sprain with acute cervical C6-7 radiculopathy and acute lumbar L5-S1 radiculopathy." Treatment consisted of five days of inpatient bedrest and traction, IM medications and muscle relaxants.

E. On March 22, 1994, a cervical MRI was performed which showed chronic spondylytic changes and a partial compression fracture at C6 without herniation or cord impingement.

F. On April 13, 1994, Patient A.H. was admitted to the hospital by respondent for treatment of a diagnosed "acute C5-6 and C6-7 cervical radiculopathy and cervical spondylosis." Respondent recorded in her discharge summary that the patient's neurosurgeon "felt there was cervical stenosis with spinal cord compromise at C4-5 and C3-4." The patient was treated with five days of inpatient bedrest and cervical traction.

G. On May 11, 1994, Patient A.H. was again admitted to the hospital for treatment of "acute C6-7 and C5-6 cervical radiculopathy, cervical spondylosis, acute L5-S1 lumbar radiculopathy left greater than right." Although referred to as "acute" these symptoms were attributed to a December, 1993 automobile accident. Sensation was reported as normal, except for modest distal peripheral neuropathy. Treatment consisted of bedrest, traction and

medication.

H. On June 13, 1994, Patient A.H. was admitted to St. Mary's Hospital by respondent for treatment of "increasing severe neck pain radiating into the left upper arm, aggravated by motion and turning his head to the left." The patient's complaints of neck pain were stated to be accompanied by pain to the low back with radiation into both buttocks, especially on the right. Respondent's diagnosis continued to be: "Acute C5-6 and C6-7 radiculopathy. Acute L5-S1 lumbar radiculopathy, right greater than left. Cervical spondylosis." Treatment was, as in prior months, with bedrest, traction and medication.

I. On August 10, 1994, Patient A.H. was admitted to the hospital for neck and back pain, which was said to radiate into the extremities. Respondent's discharge summary reported that an MRI of the cervical spine revealed "C3-4 herniation on the right, bilateral foraminal stenosis C5-6 and C6-7, posterior osteophytes, and C3-4 and C4-5 canal stenosis." Treatment consisted of bedrest, traction and medication.

J. On September 24, 1994, Patient A.H. was admitted after a fall "with his right foot underneath the car." To this fall respondent attributed acute neck and back pain. Neck pain was stated to radiate into the right arm and forearm, while back pain was stated to radiate across both buttocks and both thighs, especially in the left thigh and calf. Respondent's diagnosis was "acute C5-6 and C6-7 radiculopathy; acute lumbar sprain, acute L5-S1 radiculopathy; minimal diabetic neuropathy and cervical spondylosis." Six days inpatient bedrest, traction and medications were ordered.

J. On December 8, 1994, Patient A.H. was re-admitted for complaints which were reported to be secondary to his fall "underneath a car while trying to get out." Neck pain was stated to radiate into the left arm, while back pain was described as radiating into both legs, especially the left thigh and calf. The patient was treated with six days bedrest and traction for a diagnosis of "acute C6-7 cervical radiculopathy acute L5-S1 radicular pain, cervical spondylosis, cervical canal stensosis, lumbar radiculopathy L5-S1."

K. On February 15, 1995, Patient A.H. was admitted for complaints described by respondent as increasingly severe pain, "tingling and pain down both arms, and failure of

outpatient treatment. Five days bedrest and traction, with medications and muscle relaxants, were ordered by respondent for a diagnosis of C5-6 and C6-7 radiculopathy.

L. On April 3, 1995, Patient A.H. was admitted to St. Mary's Hospital for five days bedrest and traction for an "acute onset of neck pain radiating to the left arm and forearm but also the right forearm in the C6 distribution." The patient was stated to also be suffering from low back pain that radiated into the left thigh and calf, with tingling in the left big toe. The diagnosis was Acute C5-6 and C6-7 radiculopathy and acute L5-S1lumbar radiculopathy.

M. On June 5, 1995, Patient A.H. was again admitted. Findings on examination included depressed left biceps and triceps reflexes, bilateral triceps weakness, bilaterally positive straight leg raising, depressed left knee and ankle jerks, weak left foot dorsiflexion and a distal peripheral neuropathy. Diagnosis and treatment were as before.

N. On July 10, August 14 and September 25, 1995, Patient A.H. was re-admitted to St. Mary's Hospital – each time for treatment of multi-level lumbar and cervical radiculopathies and in each case for bedrest and traction.

O. On December 11, 1995, Respondent admitted A.H. to St. Mary's Hospital. The patient continued to have complaints of pain radiating down both arms from the neck and from the back into his thighs and calves. The patient's symptoms were attributed to the fall from a chair two years prior to admission and from an automobile accident, one year prior to admission. Respondent's diagnosis was acute C-6 radiculopathy and Acute L5-S1 radiculopathy. Bedrest, traction, IM medications and muscle relaxants were the treatment provided.

P. On January 29, 1996, respondent admitted A.H. for acute onset of back pain radiating into the thighs and calves, left greater than right, such that the patient' left leg was stated to have given out under him. The patient also was said to have acute onset neck pain, which respondent described as radiating down the right arm and forearm. There was a sensory loss to pinprick in the L5 dermatome a distal peripheral neuropathy. Treatment was with bedrest, traction and medications. Diagnoses were acute C6 radiculopathy, acute L5-S1 lumbar radiculopathy and cervical spondylosis. Patient A.H. was discharged with Motrin, 600 mg. bid

for pain.

Q. On March 11, 1996, Patient A.H. was admitted for the same complaints of pain radiating from the neck into the arms, although this time stated as greater on the left than right. Respondent' discharge summary indicates that the patient was seen by a neurosurgeon and that the neurosurgeon recommended that the patient should have a fusion of the cervical spine. The patient continued to seek conservative treatment and respondent hospitalized him -- with bedrest, traction and medication -- until March 16, 1996. Respondent re-admitted Patient A.H. on April 10, 1996 for acute L5-S1 radiculopathy and again on May 13, 1996, for treatment of acute C5-6 and C6-7 cervical radiculopathy and acute L5-S1 lumbar radiculopathy. In each case, the treatment consisted of the same bedrest, traction and medication that respondent had employed for several years without any lasting improvement in the patient's condition.

15. Patient M.F. (Medical Record no. 497679)

A. In and before February, 1993, Patient M.F. was a 52 year old female under respondent's care for treatment of multiple complaints, including chronic neck and back pain. In and after 1993, respondent admitted Patient M.F. to St. Mary's Hospital on many occasions for treatment of her neck and back complaints with in-patient bedrest, traction and medication.

B. On February 17, 1993, respondent admitted Patient M.F. to the hospital. Respondent's discharge summary indicates that the patient fell hard upon her back when her left leg gave out. Respondent reported that the patient had acute back pain across both buttocks and into the thighs, as well as neck pain which radiated into the left arm and which was associated with numbness in the left forearm. Left biceps and triceps reflexes were depressed, straight leg raising was positive bilaterally but greater on the right, left knee and ankle jerks were depressed, as was sensation left C6-C7 and left L5-S1. Respondent's diagnosis was "acute L5-S1 radiculopathy, left greater than right" and "acute cervical radiculopathy, C5-6," for which respondent provided treatment in the form of bedrest, traction and IM medications and muscle relaxants.

C. On May 10, 1993, respondent admitted Patient M.F. to the hospital following a fall at home one month previous to admission. Physical examination demonstrated

tenderness at the C5, C7 area, spasm of the trapezius and neck tenderness. Motor examination showed depressed biceps reflexes, positive straight leg raising bilaterally, depressed ankle jerk on the left and weakness of the left extensor hallucis longus. Sensor examination showed decreased sensation in the L5-S1 distribution. The patient's diagnosis was "acute C6 cervical radiculopathy, left, and acute lumbar radiculopathy L5-S1. Treatment was with bedrest, traction and medication.

D. On November 11, 1993, respondent admitted Patient M.F. to the hospital a few weeks prior to admission. The patient was stated to have slipped and fallen at home, striking her lower back. Pain was described, as before, as radiating to both buttocks and thighs. Her fall was attributed to weakness of the left leg secondary to torn left meniscus. Respondent's impression was acute lumbosacral pain secondary to acute fall, acute L5-S1 lumbar radiculopathy, left greater than right. Treatment consisted of continuous traction, immobilization, intramuscular medications and muscle relaxants.

E. On February 24, 1994, respondent admitted Patient M.F. to the hospital after an incident several weeks prior to admission when the patient's left leg gave out under her and she fell. On physical examination, respondent reported that there was tenderness C5-7, depressed right biceps reflexes, very tender L4-5, paralumbar spasm, positive straight leg raising bilaterally, depressed left knee and ankle jerks. Respondent's impression was: "Acute L5-S1 lumbar sprain. Acute L5-S1 lumbar radiculopathy on the left. Herniated nucleus pulposus L4-5." Treatment consisted of continuous traction, immobilization, intramuscular medications and muscle relaxants.

F. On June 6, 1994, respondent admitted Patient M.F. to the hospital, reportedly three weeks after a fall at home. Respondent's diagnosis was "acute lumbar radiculopathy, L5-S1" and treatment was with traction and bedrest.

G. On September 22, 1994, respondent again admitted Patient M.F. to the hospital. The reason for the hospitalization was stated to be a fall which occurred as the patient was getting out of the shower two weeks prior to admission. The patient reportedly struck her neck and back in the fall. Physical examination showed spasm with tenderness over C5-7. Other

findings were similar to those on prior admissions, except sensory examination, which indicated "decreased sensation to pin over the left calf in an L5-6 distribution." Respondent's diagnosis was: "Acute cervical lumbar sprain; acute L5-S1 lumbar radiculopathy; C5-6 cervical radicular pain." The patient was treated with continuous traction and immobilization, intramuscular medications [and] muscle relaxants . . ."

H. On November 2, 1994, respondent diagnosed Patient M.F. with acute cervical lumbar sprain, acute C5-5 cervical radiculopathy and acute L5-S1 lumbar radiculopathy. Patient M.F. was reported to have had another fall three weeks prior to admission in which she struck her head and back. An MRI was performed on the patient's left knee, which showed only arthritic changes. Treatment was as on previous admissions.

I. On June 5, 1995, respondent admitted Patient M.F. to the hospital. Respondent stated the reason for the admission was a fall at home 1 ½ weeks previously, in which the patient struck her lower back. The patient was stated to have low back pain and muscle spasms which radiated to both buttocks, especially on the left, and into the left thigh and calf. Physical examination showed symptoms similar to those exhibited on prior examinations. Respondent's diagnosis was acute L5-S1 lumbar radiculopathy. Treatment was traction and bedrest, as before.

J. On September 11, 1995, respondent admitted Patient M.F. to the hospital after the patient suffered a fall at home three weeks previously and developed severe back pain with spasm radiating into the left thigh and calf. Although the findings on physical examination were similar to the patient's prior complaints, respondent diagnosed the patient with "acute lumbar sprain with acute L5-S1 lumbar radiculopathy. Some cervical C5 root irritation as well." The patient was treated with traction and bedrest, albeit this modality of treatment had so far failed to provide any lasting relief.

K. On October 23, 1995, the patient was again admitted subsequent to a fall. The patient's fall was again attributed to weakness and instability of the left leg and knee, causing the leg to give way beneath M.F. Examination showed essentially equal upper extremity reflexes, low back tenderness, bilaterally positive straight leg raising, depressed left

knee and ankle jerks, knee swelling and effusion, weak left dorsiflexion, decreased perception to pinprick in the L5-S1 distribution on the left. Respondent's diagnosis was "acute L5-S1 lumbar radiculopathy secondary to fall at home and acute shoulder, cervical and lumbosacral strain." The patient was treated with continuous traction, immobilization, intramuscular medications and muscle relaxants.

L. On November 13, 1995, respondent admitted Patient M.F. for treatment of low back pain described as resulting from a fall two weeks prior to admission. Respondent's findings on examination included tenderness over the left sciatic notch, positive straight leg raising bilaterally, depressed left ankle jerk, weakness of the left extensor hallucis longus and left anterior tibial and continued swelling of the left knee. Respondent's diagnosis was acute L5-S1 lumbar radiculopathy and treatment consisted of bedrest, traction and medication.

M. On January 29, 1996, respondent admitted Patient M.F. for treatment of back pain after the patient twisted her back while trying to avoid a fall. Findings on physical examination were reported to be similar to those on prior hospitalizations. Although the patient now had numerous admissions after a fall or near fall, respondent did not address the reason for the patient's repeated falls. Instead, she diagnosed the patient with acute L5-S1 lumbar radiculopathy and treated her with bedrest, traction and medication.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts, Incompetence)

16. Respondent is subject to disciplinary action under Business and Professions Code section 2234(c) and/or (d) in that respondent committed repeated negligent acts and/or demonstrated lack of knowledge or ability in the care and treatment of her patients A.S., D.A., L.W., M.P., C.S., A.H. and M.F., including but not limited to the following:

A. Complainant incorporates the allegations set forth in the Paragraphs 9(A)-(J), 10(A)-(L), 11(A)-(D), 12(A)-(C), 13(A)-(G), 14(A)-(Q), 15(A)- (M) as though fully set forth herein.

B. Respondent demonstrated a lack of knowledge of medical terminology and pathophysiological concepts, such as "acute"and "radiculopathy;"

C. Respondent failed to perform reliable, reproducible physical examinations;

D. Respondent repeatedly made unusual and unlikely diagnoses, which were unsubstantiated by physical or radiological findings, and failed to consider other possible and more common causes for her patients neck and/or back pain;

E. Respondent repeatedly ordered outmoded and inappropriate modalities, such as traction, for treating her patients' chronic pain and failed to order appropriate and effective modalities, such as physical therapy and/or pharmacologic management;

F. Respondent persisted in utilizing bedrest and traction despite evidence that multiple prior hospitalizations for treatment with these modalities had been ineffective and despite information that, in general, such treatment was potentially more harmful than helpful;

G. Respondent demonstrated a lack of knowledge and ability in assessing the causes of neck and pack pain and demonstrated a lack of knowledge of currently accepted treatment modalities for treatment of patients with chronic neck and/or back pain;

H. Respondent failed to perform an appropriate work-up for her patients with repeated falling accidents, such as Patient C.S.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

17. Respondent is subject to disciplinary action under Business and Professions Code section 2234(b) in that respondent was grossly negligent in her care of Patient L.W. including, but not limited to, the following:

A. Complainant incorporates the allegations of Paragraphs 11(A)-11(D) above, as though fully set forth herein.

B. Respondent failed to conduct a standard of care evaluation for cervical myelopathy (cord compression), which is a serious and potentially disabling condition;

C. Respondent ordered inappropriate treatment for cervical myelopathy;

D. Respondent failed to obtain appropriate tests and/or surgical consultations for cervical myelopathy;

E. Alternatively, respondent failed to properly assess and/or diagnose Patient L.W.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 11513, issued to Borina Dramov, M.D.;

2. Revoking, suspending or denying approval of Borina Dramov, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering Borina Dramov, M.D. to pay the Division of Medical Quality the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring;

4. Taking such other and further action as deemed necessary and proper.

DATED: November 15, 2001.

for RON JOSEPH
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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